Fairbanks Dental Associates

Patient Registration Form

Patient Name_____ Birthdate_____
Age_____ Marital Status (optional) Single _____ Married _____ Divorced _____ Widowed _____

Social Security Number_____ Driver License Number_____

Home Address_____ Zip_____

Home Number (____) _____ Cell Phone (____) _____

Employer Name and Address _____

Occupation_____ Work Number (____) _____

Person Responsible for Account _____ Relationship_____

Social Security Number_____ Birthdate _____

Phone Number (____) _____

Home Address (if different) _____ Zip _____

Employer Name and Address _____

Occupation_____ Work Number (___) _____

Referred By _____ Physician _____

Email Address _____

Emergency Contact Information:

Name & Relationship_____

Address_____

Telephone_____

Primary Dental Insurance Information

Insured's Name_____

Insured's DOB_____

Insured Employer_____

Insurance Company_____

Group # and Phone #_____

Secondary Dental Insurance Information

Insured's Name_____

Insured's DOB_____

Insured Employer_____

Insurance Company_____

Group # and Phone #_____

I will be paying today by:

- ○ Cash
- ○ Credit Card
- ○ Check
- ○ Care Credit

Please check the box if your answer is YES to any of the following questions:

- ○ Have you been hospitalized or had any surgeries in the last 5 years?
  *If yes, reason*_____
- ○ Are you currently receiving medial care? If yes, nature of care_____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

3. _____

4. _____

For the following questions check the box for yes. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

- ○ Does dental treatment make you nervous?
- ○ Do you have dry mouth?
- ○ Anemia or Blood Disorder
- ○ Hepatitis, which type_____
- ○ Arthritis, Rheumatism or other inflammatory disease?
- ○ Joint Replacement?
  When was it placed_____
- ○ Asthma
- ○ Allergies
- ○ Kidney Disease
- ○ Abnormal Bleeding from a cut?
- ○ Liver Disease (including Jaundice)
- ○ Cancer or Tumor
- ○ Sore/ Enlarged Lymph Nodes
- ○ Diabetes: If yes, Type I or Type II. _____
- ○ Psychosis
- ○ Emphysema or Respiratory/ Lung Illness
- ○ Previous Biopsies
- ○ Epilepsy
- ○ Radiation or Chemotherapy Treatment
- ○ Fainting or Dizzy Spells
- ○ Rheumatic Fever
- ○ Glaucoma
- ○ Slow- Healing Mouth Sores
- ○ Sexually Transmitted Disease (STD)
- ○ H.I.V infection/ AIDS or ARC
- ○ Unintentional Weight Loss/Gain
- ○ Heart valve (artificial) or Heart Transplant
- ○ Pacemaker
- ○ Defibrillator
- ○ Heart Disease, Heart Attack, Heart Surgery
- ○ Heart Murmur (Mitral Valve Prolapse)
- ○ Abnormal Heart or Previous Bacterial Endocarditis
- ○ Heart Stent? If yes, when was it placed_____
- ○ Recurrent Illnesses? Please list_____
  _____

Are you taking any of these Medications?

- ○ Pre- medication before dental treatment? If yes, please list_____
- ○ Blood Thinners (Coumadin®, Warfarin®, Heparin®, Plavix®)
- ○ High Blood Pressure Medications
- ○ Antacids such as Tagamet® (cimetidine) or Prilosec® (omeprazole)
- ○ Sedatives
- ○ Sleep Aid medication
- ○ Tranquillizers
- ○ Cardizem® (diltiazem) or Calan
- ○ Isoptin® (Verapamil)

- Dilantin® or Tegretol®
- Serzone® (nefazodone)
- Barbiturates (any)
- Diflucan® (fluconazole) or Sporonox® (itraconazole)
- St. John's Wort or Kava- Kava
- Biaxin® (clarithromycin)
- Have you been treated with Bisphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)

  *If so, when did the treatment begin*_____

  *When did the treatment end*_____
- Have you ever taken any prescription drugs such as Fen-Phen for weight loss
- Do you consume grapefruit juice, grapefruits or grapefruit extract

Please list any medications you are currently taking:

1._____ 5._____

2._____ 6._____

3._____

4._____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Female:

- Are you pregnant
- If no, are you planning a pregnancy in the near future
- Are you a nursing mother
- Are you taking birth control pills

Male & Female:

- Abnormal Blood Pressure
- Have you ever received a diagnosis of "High Blood Pressure"

  What is your normal blood pressure: _____/_____ *Today:* _____/_____

Are you allergic or have you had a reaction to any of the following:

- Local anesthetics (please list) _____
- Penicillin or other antibiotics (please list) _____
- Aspirin, Ibuprofen, or Tylenol (please circle)
- Codeine, Valium, or other sedatives (please list) _____

- Latex or Metals (please circle)
- Other_____

Alcohol and Drugs

- Do you consume alcohol? *If yes, approximately how many alcoholic beverages per week?*
- Do you use ant mood altering drugs other than those previously listed? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medications.

_____	_____	_____
Patient (Print Name)	Patient Signature	Date
Dr. Christopher Fairbanks	_____	_____
Doctor	Doctor Signature	Date

If I could change my smile at an affordable cost, I would:

- Whiten my teeth
- Replace missing teeth
- Replace broken fillings
- Straighten my teeth
- Close unwanted spaces
- Repair loose, misaligned or shifting teeth
- Replace black material fillings with tooth colored restorations
- Improve bad breath
- Repair chipped teeth

Are you experiencing any of the following symptoms?

TMJ:

- Jaw joint pain
- Popping or stiffness of the jaws joint
- Grinding or clenching teeth
- Headaches earaches, neck pain

Periodontal Disease:

- Bleeding, swollen, sore, red, inflamed or irritated gums (Please circle all that apply)
- Foul taste
- Food Impaction

- Loose or shifting teeth
- Sensitivity (hot, cold, sweet) Where? Upper Right Lower Right Upper Left Lower Left
- Do you smoke or use chewing tobacco? How much? _____ For how long? _____

Have you had any of the following done?

- Replaced missing teeth
- Replaced old crowns that didn't match
- Dentures
- Smile Makeover
- Partial Dentures
- Braces
- Periodontal (gum) treatments

Please Share the following dates:

Your last dental visit_____ Your last cleaning_____

Your last oral cancer screening_____ Your last complete X-Rays_____

On a scale of 1-10, with 10 being the highest rating, please rate the following:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Whom may we thank for referring you to our office?

Patient:_____Website Google Mailer Facebook Newspaper

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, Discover, Care Credit and Debit Cards. Outside financing is available upon request and approval.

Do You Have Insurance?

_____ As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid, usually 20% to 75%. We will, of course, do all we can to make sure your estimate is as accurate as possible.

_____ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

_____ We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

_____ We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express, Discover or our bank financing plans (Care Credit is available). Please inquire at the front desk if interested at the time we provide the service to you.

_____ Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

_____ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

I HAVE READ, UNDERTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

CONSENT:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a credit report from a credit reporting agency if I would like to be considered for one of the payment plans offered such as Care Credit no interest financing. I will notify you of any changes in my health status or the above information.

Patient Signature_____ Date_____
(or Parent/ Guardian of child/ minor)