Webster Dental Care
ADULT REGISTRATION FORM

PATIENT INFORMATION:

Today's Date: _____

Patient Name: _____ _____
LAST, FIRST M.I.

Date of Birth_____ Social Security #: _____

Gender: Male: □ Female: □ Drivers License #: _____

Address: _____
STREET CITY , STATE ZIP

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Emergency Name and # or someone not in your household: _____

Has any member of your family been treated in our office?: _____

DENTAL INSURANCE INFORMATION:
Primary Policy:

Name of Insured: _____ _____ D.O.B:_____
LAST, FIRST M.I.
Employer: _____ Insurance Co:_____

Group #: _____ ID#: _____ Ins. Phone #: _____

Claims Address: _____

Secondary Insurance: (We do not accept assignment of benefits from your secondary policy, but will gladly electronically bill them and they can reimburse you)

Name of Insured: _____ _____ D.O.B:_____
LAST, FIRST M.I.
Employer: _____ Insurance Co:_____

Group #: _____ ID#: _____ Ins. Phone #: _____

Claims Address: _____

How did you hear about our office?

□ Friend/Relative □ Computer Search
□ Current Webster Patient □ Mailing
□ Dental Insurance □ Social Media Site _____

Who may we thank for referring you to our office?_____

DENTAL HISTORY:

Reason for today's visit?

_____

Date of last dental visit? _____ Did you bring x-rays? □ YES □ NO

Why did you decide to change dental offices?

_____

Is there anything in your mouth or about your smile that you would like to change or modify? □ YES □ NO
If yes, please specify:

_____

How do you rate your dental health? □ Good □ Fair □ Bad

Do your gums bleed when you brush or floss? □ Yes □ No

Do you own an electric toothbrush? □ Yes □ No

Do you smoke or use chew tobacco? □ Yes □ No

Please check if you have or do any of the following:

□ Bad Breath
□ Blisters on Lips/Mouth
□ Clicking/Popping of Jaw
□ Clenching of Teeth
□ Grind Teeth
□ Broken/Loose Teeth or Filling
□ Sensitivity to Biting
□ Sensitivity to Sweets
□ Sensitivity to Hot/Cold
□ Jaw Pain
□ Ear Pain
□ Headaches
□ Dry Mouth
□ Missing Teeth
□ Sores or Growths in your Mouth
□ Mouth Breather
□ Suck Your Thumb
□ Food Collecting Between Teeth

Have you been treated for any of the following?

□ Orthodontics □ Periodontal Disease □ Sleep Apnea or Snoring

Are you afraid of the dentist or have you had a bad experience? □ Yes □ No

Do you have any allergies or have you had any bad reactions to:

□ Local Anesthetic
□ Antibiotics _____
□ Latex
□ Other _____

MEDICAL HISTORY:

Are you under physician's care? □ Yes □ No If yes, for what? _____

Physician's name: _____ Physician's #: _____

Please list medications and other pills you are taking:

_____

Do you generally take antibiotics before a dental visit? □ Yes □ No

Please check any and all that you have had: (indicate date if possible)

□ Heart Disease	□ Diabetes	□ Cancer	□ Glaucoma
□ Shortness of Breath	□ Thyroid Problems	□ Radiation	□ Osteoporosis
□ Pacemaker	□ Respiratory Problems	□ Shingles	□ Artificial Joints
□ Rheumatic Fever	□ Psychiatric Issues	□ Chemotherapy	□ Hepatitis
□ Heart Murmurs	□ Nervous Disorders	□ Arthritis	□ Asthma
□ Stroke	□ Liver Disease	□ Blood Disorders	□ HIV/Aids
□ Abnormal Blood Pressure	□ Kidney Disease	□ Sleep Apnea	□ Epilepsy and Seizures
□ Major Surgery	□ Fainting or Dizziness	□ Bleeding/Clotting	

Are there any other medical issues or conditions not listed that we should know about?

_____

Females: Are you pregnant or trying to get pregnant? □ Yes □ No Are you nursing? □ Yes □ No
Are you on birth control pills? □ Yes □ No

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

Signature of patient or guardian: _____ Date: _____

CONSENT FOR TREATMENT:

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of _____'s dental needs.
   NAME OF PATIENT
2. Upon such diagnosis, I authorize the Doctor and/or Hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.

3. I agree to the use of anesthetics and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.

4. A fee if $1.00 per minute of appointment time will be charged if an appointment is cancelled without 24 hours notice.

Patient or Guardian (Printed): _____

Signature of Patient or Guardian: _____ Date: _____

FINANCIAL AND OTHER POLICIES:

I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the **estimated** copayment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected copayment from historical data. If you want a more accurate estimate, ask to have **a pretreatment estimate** to your insurance company. We will gladly submit your insurance claim to the insurance address you gave us. If we do not get paid within 30 days of submission of the claim we will look to you for full payment of your bill. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a written payment plan has been made. We accept cash, checks, money orders and all major credit cards for your payments.

Assignment of Benefits: I hereby authorize my insurance company to pay directly to Webster Dental Care benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws will be charged on the unpaid principle balance on all accounts not paid within 60 days of the treatment date. I further understand the fee estimates listed for my dental care can only be extended for a period of six months from the date the estimate was written.

After 90 days from the date of service any unpaid accounts will be referred to a collection agency. I will then be responsible for my balance plus an additional 30% of the unpaid balance as the agency fee and any attorney's fees. I grant my permission to you, or your assigns to telephone me at my home or place of employment to discuss matters related to this form, my treatment or billing issues.

I understand that there is a $1.00 per minute of appointment time charged for appointments cancelled with less than 24 hours notice.

Please silence your cell phones when in the treatment rooms.

Warning: Do not sign this if you have any questions about the financial policies of our offices. If you have any questions, ask one of our financial coordinators before signing this paper.

In accordance with HIPAA, I agree to the disclosure of my protected health information to my insurance company. I authorize my insurance company to pay Webster Dental directly.
I have read the above Financial and Other Policies and agree to the content.

Signed: _____ Date: _____

Webster Dental Care Acknowledgement of Receipt of Notice of Privacy Practice:
(Please notify clerk if you refuse to sign this Acknowledgement)

I, _____have received a copy of the office's Notice of Privacy Practice.

Printed Name: _____

Signature: _____ Date: _____