

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_  
 Referred By: \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Emergency Contact #: \_\_\_\_\_  
 Physician name: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sidde Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes \_\_\_\_\_

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X \_\_\_\_\_

Date: \_\_\_\_\_



**SHELDON GROVE  
FAMILY DENTAL**

**EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work#: \_\_\_\_\_  
Mobile #: \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal physician?  
 Yes  No  
Physicians name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_

**Please share the following approximate dates:**

Your last cleaning: \_\_\_\_\_

Your last complete x-rays: \_\_\_\_\_

**Are you nervous about coming to the dentist?**

A lot  A little  Not at all

**How did you hear about us?**

Phone Book  Internet  Friend/Relative  
 Mailer  Sign  Other: \_\_\_\_\_

**If you could change your smile, would you:**

(Please check all the apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match

**Please check any of the following problems that apply to you:**

- Sensitivity (hot, cold, or sweet)  
If so, which teeth \_\_\_\_\_
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Difficulty opening, closing or chewing
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath

**What is the most important objective for your dental visit?**

\_\_\_\_\_  
\_\_\_\_\_

**DISCLAIMER, AUTHORIZATION & RELEASE**

I authorize Dr. Cervantes to release information including diagnosis and records of any treatment or exam rendered to me or my child during the period of dental care to third party payers and health practitioners. I authorize and request my insurance company to pay directly to Dr. Cervantes benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that I may be charged interest on balances over 60 days old. I further authorize Dr. Cervantes to run credit checks as necessary when providing credit.

\_\_\_\_\_  
Signature (Of patient or parent if minor)      Date

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

**Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA**



## Sheldon Grove Family Dental-Office Policies

**Financial Policy: It is our policy to receive the patient's portion of payment in full at time of service.** Our office works directly with the insurance company and will bill them as a courtesy to you. For your convenience, we accept cash, personal checks, money orders, and credit card payments at the time of service. The practice also has an arrangement with CareCredit that may also fit your needs.

*If you carry a balance in our office that is over 90 days old your account will be charged a 2% finance charge (compounded monthly) until balances are paid in full, unless other arrangements have been made with the office manager.*

**Insurance: We will file all dental claims for you on your behalf as a courtesy, but the patient is ultimately responsible for all charges.** We will submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee an estimated coverage. Please read your policy thoroughly to be aware of the benefits provided and the limitations imposed. You should be aware that all insurance companies differ in the types of coverage available. Some companies process claims promptly, while other delay payments for months. Since SGFD is not a party to the agreement you have with your insurance company, you will be held accountable for all charges. If your insurance company has not paid their portion within a reasonable amount of time (generally ninety days), you will be asked to take care of any outstanding balance.

**Estimates: We will give you an estimate for your portion based on the information given to us by your insurance carrier. Please remember that this is only an estimate.** We will provide you with written treatment plans at all appointments where needed. A treatment plan estimate include our fee, the estimated insurance benefit, and what your patient portion amount. Treatment plans may change depending on the patient needs. We will always do our best to keep you informed of any changes.

**Broken Appointments: There is a \$50 penalty fee for broken or failed appointments less than 48 hours notice.** We understand that life can be very busy and is filled with unforeseen circumstances. However, should you need to need to reschedule an appointment, please inform us within 48 hours of your appointment. Two or more missed appointments without notification may result in dismissal from the practice.

**I have received the office policies and have been given the opportunity to ask questions to clarify any policy I did not understand.**

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date