Patient Registration

Holmes FAMILY & COSMETIC DENTISTRY
10435 Illinois Road, Fort Wayne, IN 46814
Ph: (260)469-3671 | www.holmesfamilydentistry.com

Patient Name:_____ Gender: ○ M ○ F Birth Date:_____ Today's Date:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____ Cell Phone:_____ Home Phone:_____

Social Sec. #:_____ Please Check One: ○ Single ○ Married ○ Separated ○ Widowed

Work Phone:_____ Your Employer:_____ Occupation:_____

Person Responsible for Account:_____ Parent if Patient is a Minor:_____

How did you hear about our office?_____ Reason for Visit:_____

EMERGENCY INFORMATION *(A relative not living with you)*

Name:_____ Address:_____ Telephone:_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name:	DOB:	SS#:
Insured's Employer:	Insurance Co.:	
Phone Number:	Group Number:	Local #:

Do you have Secondary Dental Insurance?

○ Yes ○ No

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality 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. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company. Our office accepts cash, all major credit cards, and outside financing information is available upon request. Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

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. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- 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.
- 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.

We thank you for the opportunity to serve your dental health care needs and welcome questions you may have concerning your care or our financial policy.

CONSENT

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

The undersigned, hereby 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 responsibility for payment for dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Patient's Signature (Parent of Child) Date

SUBMIT

Dental History

Holmes FAMILY & COSMETIC DENTISTRY
10435 Illinois Road, Fort Wayne, IN 46814
Ph: (260)469-3671 | www.holmesfamilydentistry.com

Referred by:_____ How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist:_____ How long have you been a patient?_____ Months/Years:_____

Date of most recent dental exam: _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ○3 mo. ○4 mo. ○6 mo. ○12 mo. ○Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY ○○○	NO	YES
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	○	○
2. Have you had an unfavorable dental experience?	○	○
3. Have you ever had complications from past dental treatment?	○	○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	○	○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	○	○
6. Have you had any teeth removed or missing teeth that never developed?	○	○
GUM AND BONE ○○○		
7. Do your gums bleed or are they painful when brushing or flossing?	○	○
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	○	○
9. Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
10. Is there anyone with a history of periodontal disease in your family?	○	○
11. Have you ever experienced gum recession?	○	○
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	○	○
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	○	○
TOOTH STRUCTURE ○○○		
14. Have you had any cavities within the past 3 years?	○	○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	○	○
18. Do you have grooves or notches on your teeth near the gum line?	○	○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	○	○
20. Do you frequently get food caught between any teeth?	○	○
BITE AND JAW JOINT ○○○		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	○	○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	○	○
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	○	○
25. Are your teeth becoming more crooked, crowded, or overlapped?	○	○
26. Are your teeth developing spaces or becoming more loose?	○	○
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
30. Do you clench your teeth in the daytime or make them sore?	○	○
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	○	○
32. Do you wear or have you ever worn a bite appliance?	○	○
SMILE CHARACTERISTICS ○○○		
33. Is there anything about the appearance of your teeth that you would like to change?	○	○
34. Have you ever whitened (bleached) your teeth?	○	○
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
36. Have you been disappointed with the appearance of previous dental work?	○	○

Patient's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

SUBMIT

Medical History

Holmes FAMILY & COSMETIC DENTISTRY
10435 Illinois Road, Fort Wayne, IN 46814
Ph: (260)469-3671 | www.holmesfamilydentistry.com

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician/and their specialty: _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? ○ Excellent ○ Good ○ Fair ○ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	NO	YES
1. hospitalization for illness or injury	○	○
2. an allergic reaction to: aspirin, ibuprofen, acetaminophen, codeine	○	○
penicillin	○	○
erythromycin	○	○
tetracycline	○	○
sulfa	○	○
local anesthetic	○	○
fluoride	○	○
metals (nickel, gold, silver, _____)	○	○
latex	○	○
other	○	○
3. heart problems, or cardiac stent within the last six months	○	○
4. history of infective endocarditis	○	○
5. artificial heart valve, repaired heart defect	○	○
6. pacemaker or implantable defibrillator	○	○
7. orthopedic implant (joint replacement)	○	○
8. rheumatic or scarlet fever	○	○
9. high blood pressure	○	○
10. a stroke	○	○
11. anemia or other blood disorder	○	○
12. prolonged bleeding due to a slight cut (INR > 3.5)	○	○
13. emphysema, shortness of breath, sarcoidosis	○	○
14. tuberculosis, measles, chicken pox	○	○
15. asthma	○	○
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	○	○
17. kidney disease	○	○
18. liver disease	○	○
19. jaundice	○	○
20. thyroid, parathyroid disease, or calcium deficiency	○	○
21. hormone deficiency	○	○
22. high cholesterol or taking statin drugs	○	○
23. diabetes (HbA1c =_____)	○	○

	NO	YES
24. stomach or duodenal ulcer	○	○
25. digestive disorders (i.e. celiac disease, gastric reflux)	○	○
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	○	○
27. arthritis	○	○
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	○	○
29. glaucoma	○	○
30. head or neck injuries	○	○
31. epilepsy, convulsions (seizures)	○	○
32. neurologic disorders (ADD/ADHD, prion disease)	○	○
33. viral infections and cold sores	○	○
34. any lumps or swelling in the mouth	○	○
35. hives, skin rash, hay fever	○	○
36. sexually tranismitted disease, HIV, or HPV	○	○
37. hepatitis (type _____)	○	○
38. HIV / AIDS	○	○
39. tumor, abnormal growth	○	○
40. radiation therapy	○	○
41. chemotherapy, immunosuppressive medication	○	○
42. psychiatric treatment	○	○
43. antidepressant medication	○	○
44. alcohol / recreational drug use	○	○
ARE YOU:		
45. presently being treated for any other illness	○	○
46. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	○	○
47. taking medication for weight management	○	○
48. taking dietary supplements	○	○
49. often exhausted or fatigued	○	○
50. experiencing frequent headaches	○	○
51. a smoker, smoked previously or use smokeless tobacco	○	○
52. often unhappy or depressed	○	○
53. currently pregnant	○	○

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS.

DRUG	PURPOSE

DRUG	PURPOSE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: Date: _____

Doctor's Signature: Date: _____

SUBMIT

Holmes FAMILY & COSMETIC DENTISTRY

10435 Illinois Road, Fort Wayne, IN 46814
Ph: (260)469-3671 | www.holmesfamilydentistry.com

Authorization of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign the acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Policies.

Please print name: _____

Signature: _____ Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Please print name: _____ Relationship: _____

Please print name: _____ Relationship: _____

Please print name: _____ Relationship: _____

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other _____

SUBMIT