ENAMEL DENTAL

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Patient Registration Form

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

SSN# _____ Sex M☐ F☐ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☒Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. I may opt-out of receiving electronic communications at any time.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible Party, if under 18)

DENTAL & MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? _____		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain _____

_____

_____

Have you ever had trouble from previous dental care?

☐Yes ☐No If Yes, please explain _____

_____

_____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ _____Blood Pressure_____

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe _____

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates _____

(Women) Are you pregnant? Yes☐ No ☐ Due date _____ Nursing? Yes ☐ No☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies/Anaphylaxis	☐	☐	Headaches	☐	☐	Slow healing wounds	☐	☐
Anemia	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Arthritis, Rheumatism	☐	☐	Heart problems	☐	☐	Swelling of feet or ankles	☐	☐
Artificial heart valves	☐	☐	Hepatitis type _____	☐	☐	Thyroid problems	☐	☐
Artificial joints	☐	☐	Herpes	☐	☐	Tonsilitis	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐
Required Hospitalization	☐	☐	HIV+/AIDS	☐	☐	Tumor or growth on head/neck	☐	☐
Have you used steroids	☐	☐	Jaundice	☐	☐	Ulcer	☐	☐
Date of last episode _____	☐	☐	Kidney disease	☐	☐	Venereal disease	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Liver disease	☐	☐	Weight loss, unexplained	☐	☐
Blood disease, clotting disorders	☐	☐	Mitral valve prolapse	☐	☐	Tobacco Habit?	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Do you consume alcoholic beverages?	☐	☐
Chemical dependency	☐	☐	Osteopenia	☐	☐	Are you currently under the care of a Physician?	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Are you allergic/sensitive to Latex?	☐	☐
Circulatory problems	☐	☐	Radiation treatments	☐	☐	Allergic to Penicillin, Aspirin, or other drugs?	☐	☐
Cortisone treatments	☐	☐	Respiratory disease	☐	☐	*If Yes, please specify* _____		
Cough, persistent or bloody	☐	☐	Rheumatic fever	☐	☐	_____		
Diabetes	☐	☐	Scarlet fever	☐	☐	_____		
Emphysema	☐	☐	Shortness of breath	☐	☐	List any medications that you are taking:		
Epilepsy	☐	☐	Sinus trouble	☐	☐	_____		
Fainting	☐	☐	Sickle cell anemia	☐	☐	_____		
Glaucoma	☐	☐	Skin rash	☐	☐	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

Informed Consent
General Dentistry

Chart # _____

All patients complete 1 thru 4 below, and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for al least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore,, it is critical that I tell my dentist of all medications I am current taking.

(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials _____)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials_____)

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials _____)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

8. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials _____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials _____)

9. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials _____)

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials _____)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _____)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature _____ **Date:** _____

Doctor: _____ **Date:** _____

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to view and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice at any time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occured prior to the date I revoke this consent is not affected.

Print Patient Name **Relationship to Patient**

Signature **Date**

APPOINTMENT CANCELLATION POLICY

At Enamel Dental our goal is to provide exceptional dental care to each of our patients. In order to consistently provide an excellent experience, we have implemented an **Appointment Cancellation Policy**.

Our policy requires a 24 hour notice in the event that an appointment needs to be rescheduled. In an appointment is on a Monday, cancellations must be made by 4 PM the Friday before. If any appointment is missed entirely or if a patient is more than 20 minutes late without the office being contacted a $25.00 fee will be charged to the account. This fee will be the patient's direct responsibility, as it is not billable to insurance companies. In addition, no future appointments can be scheduled nor can records be transferred if this fee is outstanding on the account.

Our staff will be glad to answer any questions regarding this policy to provide clarification if necessary, and we thank you for your consideration.

I have read and understand the Appointment Cancellation Policy of Enamel Dental and I agree to be bound by its terms. I also understand and agree that such terms may be amended as necessary.

Print Patient Name **Relationship to Patient**

Signature **Date**