Welcome to Double Diamond Dental!

Patient Dental Registration and History Form Date: _____

Patient Information

Last Name: _____
First Name: _____ Middle Initial: ____
Social Security Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Email address: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____/_____/_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ Years

Patient Employer / School: _____
Occupation: _____
Employer/School Address: _____
_____
Employer/School Phone: _____
Spouse/Guardian Name: _____
Spouse/Guardian Birthdate: _____
Spouse/Guardian Social Security #: _____
Spouse/Guardian Employer: _____
How were you referred to us? _____

Phone Numbers

Home phone: _____ Cell: _____
Work: _____ Ext: _____
Spouse/Guardian Phone: _____

IN CASE OF EMERGENCY, CONTACT:
Name: _____
Relationship: _____
Home phone: _____ Work: _____

Dental Insurance

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Company: _____
Group #: _____ Subscriber ID: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, please provide following for secondary insurance:
Subscriber's Name: _____
Birthdate: _____ SS# _____
Relationship to patient: _____
Insurance Company: _____
Group #: _____

INSURANCE AUTHORIZATION

☐ By checking this box:

- I authorize my insurance company(ies) to pay the dentist all insurance benefits rendered.
- I authorize the use of my signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Printed name Relationship to Patient

Dental History

Reason for today's visit: _____

Former dentist: _____ City/State: _____

Date of: Last dental visit: _____ Last dental x-rays: _____ Last dental cleaning: _____

Please check all that apply. Leaving blanks will indicate a "no" response.

☐ Had complication from past dental treatment
☐ Had any reactions to local anesthetic
☐ Have dry mouth
☐ Food gets trapped between any teeth
☐ Have popping and/or clicking of your jaw/TMJ
☐ Clench or grind your teeth
☐ Have tinnitus (ringing in ears)
☐ Snore or wake up frequently during the night
☐ Gums bleed when brushing or flossing
☐ Have or had gum recession
☐ Have or had a burning sensation in your mouth
☐ Would like to change the appearance of your smile
☐ Had trouble getting numb
☐ Had or have braces (orthodontic treatment)
☐ Teeth are sensitive to hot, cold, biting or sweets
☐ Have whitened your teeth
☐ Have difficulty chewing
☐ Get headaches or migraines
☐ Neck or upper back pain
☐ Wear or have worn a bite appliance
☐ Have been treated for gum disease
☐ Had an unpleasant taste or odor in your mouth
☐ Use tobacco product(s)
☐ Have had Botox or dermal filler treatments

Medical History

Primary Physician:_____ Phone: _____ Last visit (mo/yr): _____

Medications: List any medications you are taking and the correlating diagnosis: _____

_____

_____

_____

_____

_____

_____

☐ None (no medication taken)

Pharmacy Name: _____ Phone: _____

List any recent or upcoming surgeries: _____

_____

_____

Pre-Med Requirements:

☐ Are you required to take pre-medication for your dental visits? Conditions that can require pre-med include artificial joints or heart valves, recent heart surgery and some heart murmurs). Please note pre-med requirements:

_____

_____

Women: Check all that are applicable.

☐ Pregnant (due date: _____/_____/_____)
☐ Nursing
☐ Taking birth control

Allergies:

☐ None
☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other: _____

Medical Conditions:

Check if you have had any of the following conditions:

☐ Artificial Heart Valves
☐ Artificial Joints
☐ Anxiety
☐ Autoimmune Disease
☐ Dry Mouth
☐ Excessive Bleeding
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis, Type ___
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ MitralValve Prolapse
☐ Osteoporosis/Bone Dx
☐ Radiation Treatment
☐ Recent Heart Surgery
☐ Rheumatic Fever
☐ Tuberculosis
☐ Acid Reflux
☐ Anemia
☐ Arthritis/Rheumatism
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Drug/Alcohol Use
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ High Cholesterol
☐ HPV
☐ Pacemaker
☐ Pyschiatric Disorder
☐ Respiratory Problems
☐ Sinus Problems
☐ Stroke
☐ Temporal Arteritis
☐ Ulcers
☐ Other: _____

Office Policies

Initial:	
_____	**Patients known to have a communicable disease on arrival or during treatment MUST be rescheduled.**
_____	It is the policy of this office to collect **all** patient portions at the time of service. There are no exceptions.
_____	We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.
_____	Insurance is billed as a courtesy to all our patients. Every attempt is made to determine the exact amount that your insurance will cover for any procedure, and a treatment plan will be presented prior to beginning treatment. However, the final responsibility for payment rests with the patient. Also, any outstanding balance over 60 days old automatically becomes the patient's balance.
_____	In case of unpaid balances, collection agencies and small claims court are used. Additional fees up to 40% of the outstanding balance are added. This is easily avoided by communicating with the office if there is a problem.
_____	Please let us know of any changes in your insurance policies, address and/or phone numbers as soon as possible. Current information is essential to accurately bill your insurance company on your behalf.

My signature below is to authorize:

☐ The release of pertinent information regarding my account to The Insurance Commissioner, the attorneys and/or adjusters needed to resolve my dental claims.
☐ I grant Power of Attorney to Michael A. Morgan, DDS for the purpose of depositing payments sent to the office by my insurance company(ies).
☐ I understand the privacy policy and am aware that they are available to me upon request.

Signature: _____ **Date:** _____

Double Diamond Dental

Smile Analysis

You deserve a happy and healthy smile! Tell us about yours.

Please check any statement you agree with:

- ☐ I am currently happy with the health and appearance of my smile.
- ☐ I wish the color of my teeth were whiter.
- ☐ I wish I had a bigger smile.
- ☐ I think some of my teeth are too small.
- ☐ I think some of my teeth are too large.
- ☐ I wish my teeth were straighter.
- ☐ I think my gums show too much when I smile.
- ☐ I think my smile shows too much space between some of my teeth.
- ☐ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
- ☐ I have often wished I could change some of the features of my smile.
- ☐ I feel as though I don't really know all of the options available to enhance my smile.
- ☐ Concerns over the potential end result have been a factor in my not pursuing aesthetic dentistry to enhance my smile.
- ☐ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- ☐ I feel as though I could do a better job protecting the health of my gums and, therefore, the longevity of my own smile.

When I see a picture of myself, the first thing I notice about my smile is:

_____

_____

Something I often notice about other smiles I consider attractive is:

_____

_____

Double Diamond Dental

Policy Regarding Dental Insurance

Our goal is to help you maximize your benefits!

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

We make every effort to calculate what your insurance is expected to pay; however, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance."

> *Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.*

Dental insurance companies normally do not require a "predetermination" or "prior authorization." If the insurance company does, we will be happy to submit a treatment plan to them. In order for us to submit your form, we ask that you provide a copy of your insurance card.

Please know that it often takes us a considerable amount of time to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance provider. In any case, the account needs to be paid in **60 days**.

I have read and understand the above.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date