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

Authorization and Acknowledgements

My signature below is to authorize and acknowledge:

- 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.
- I understand that I am financially responsible for all charges, whether or not paid by insurance.
- I understand that, in case of unpaid balances, collection agencies and small claims court are used and additional fees up to 40% of the outstanding balance are added.

Signature: _____ **Date:** _____

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: _____

Double Diamond Dental

Patient Responsibilities

We want to make your experience at Double Diamond Dental a friendly and exceptional one – from the time you walk into the door to the time you leave our office. We ask that you read the following patient responsibilities and initial that you understand each one. This will enable us to provide the exceptional visit to you.

_____ INITIAL	1. If you have dental insurance, please be aware of your coverage. It is your responsibility to know your insurance coverage and to inform us of any changes.
_____ INITIAL	2. Estimated portions and co-payments are due at time of service. Dental insurance doesn't Guarantee payment. We accept cash, check, and all major credit cards. Our office also offers third-party financing through "Care Credit" should you require payment options.
_____ INITIAL	3. If you do not have dental insurance, we offer an "In-Office" dental savings option. Please ask our front desk for details.
_____ INITIAL	4. Your appointment time is **RESERVED for you only**. We strive to be on time for your appointment. Please respect our time commitment to others by arriving on time for your appointment.
_____ INITIAL	5. It is your responsibility to notify us during business, **at least 48 hours in advance**, if you need to change or reschedule your appointment. We reserve the right **to charge a $75.00 fee** for appointments not given proper notice or for all **NO SHOW/FAILED** appointments.

Thank you for choosing Double Diamond Dental for your dental care. We believe that if all individuals (Doctor, Staff, Patients, and parents) accept their responsibilities in this ongoing relationship, everyone will be cared for at the Highest possible level and the lowest possible cost.

_____	_____	_____
Signature	Printed Name	Date

Double Diamond Dental

HIPAA Privacy Policy

I understand that according to the Federal HIPAA law that this office is unable to discuss my treatment, account balance or any other matters pertaining to me unless I indicate that they may do so. I agree that the following people can be informed of any association that I may have with this office, including but not limited to treatment, diagnosis, financial arrangements, account balances, and my general well-being.

Please List Names of authorized individuals and relationship to patient:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

This consent applies until I ask that the named person(s) be deleted or a new form replaces this form. I certify that I have received a copy of the Joint Notice of Privacy Practice provided by Double Diamond Dental.

Patient Signature: _____ Date: _____

_____ Date: _____

Authorized Signature above if patient is under the legal age of 18 years old

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:

_____

_____