PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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.: _____

Additional Comments:

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: _____.00 Rem. Deduct: _____.00

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: _____.00 Rem. Deduct: _____.00

Eaglesoft Medical History

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, c

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

Dr. Matthew S. Free, D.M.D.
10277 N. Straits Hwy, Cheboygan, MI 49721 www.cheboygandental.com Office Phone: (231) 627-7131

X-Ray Release Form

Date:_____

I, _____ *(print name)*, hereby authorize the release of my dental x-rays and I give my permission for them to be forwarded to other dentists or healthcare providers by mail or secure email.

Patient Information

Name:_____ Date of Birth:_____

Phone:_____

Address:_____

_____

_____

Patient's signature:_____ Date:_____

Previous Dentist information
(This helps us locate any previous up to date xrays you may have elsewhere)

Name of previous dentist: _____ Phone: _____

For office use only:

Released By (Witness): _____ *Date:*_____

Witness Name (Printed): _____

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New Patient Intake Form

Patient Name: _____ DOB: _____

Thank you for coming in today! Please answer the following questions to help us to understand your needs and preferences.

What is your primary concern you'd like us to address today?

_____

What did you like about your last dentist? _____

What did you dislike about your last dentist?_____

When considering your oral health needs, please choose one:

- □ When it comes to my oral health, I prefer to be proactive and preventative. I like to avoid complications, and I am someone who likes to prevent dental issues from even arising, potentially saving myself from pain and additional expenses.
- □ When it comes to my oral health, I consider myself to be more of a reactive person. I would rather wait and deal with dental issues after they develop, or after it has started to hurt, before addressing the matter, even if it means I need more visits, time, and potentially more expense to address the issue.

How would you rate your smile from 1 – 10?_____

What would improving your smile by 1 – point on this scale from 1 – 10 look like?

_____

Do you consume sugary and acidic food and drink on a regular basis? ☐ Yes ☐ No

How often and how many soft drinks do you consume? _____

Are you aware that you grind your teeth? ☐ Yes ☐ No

Do you snore or have sleep apnea? ☐ Yes ☐ No

Patient Name: _____

Are you aware of the oral-systemic connection? (How a healthy mouth plays a role in having a healthy heart and body) ☐ Yes ☐ No

What is the biggest obstacle for you regarding getting the dental care you need? (Please circle one)

Anxiety Time Budget No obstacles

What do you value most regarding your teeth? (Please circle one)

Cosmetic – You most value how your teeth look. Want them straight, want them white.

Function – You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side or area. No food or drink should be off limits to you.

Comfort – You most value NOT being in pain or having tooth and gum sensitivities. Example: "I can't eat this anymore because it hurts or is sensitive.

Longevity – You most value the ability to have your natural teeth forever. You want to do all you can to keep your natural teeth as healthy as possible, and for as long as possible.

Do you prefer to pay off your balances in full up front, so nothing is owed, or are you interested in learning about financing options that provide flexible monthly payments?

_____

If you do not have insurance, would you like to learn more about our in-house membership plan that helps make dental care affordable? ☐ Yes ☐ No

Do you prefer to break your appointments up into multiple shorter visits, or do you prefer less visits that are longer in duration, but save trips to the dentist? _____

Do you prefer to get any necessary treatment done today, if possible? ☐ Yes ☐ No

How did you hear about us? _____

Do you prefer peace and quiet during your visits, or do you like to be aware of each step of the procedure as it's completed? _____

Are you interested in learning more about using laughing gas or pre-appointment medication to address anxiety? _____

Would you like a blanket or a pillow during your appointment? ☐ Yes ☐ No

What is most important to you regarding having a pleasant dental visit?

_____

What is the most important thing we can do today to ensure you have a wonderful experience?

_____

What is an interesting fact about yourself? (i.e pursuits, hobbies, passions)

_____

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FINANCIAL POLICIES

Our office is committed to providing affordable dental care for our patients. We proudly offer the following financial options for payment:

- **Payment is due at time of service. We accept cash, check, and credit card.**
- **Today's Dental Membership Plan:** No insurance? No problem! Our in-house membership plan provides 2 cleaning, 2 exams, 2 fluoride applications, 50% off x-rays, and 10% off all treatment.

  Individual Plan - $209/year Couple - $309/year Child Plan - $150/year
- **5% discount on full payment in advance for treatment over $1,000**
- **We offer CareCredit with flexible payment options.** You can apply online at www.carecredit.com, or we are happy to help you with the application process to see what options are available to you.
- **Dental Insurance – Our office accepts most insurance plans:** Our office will gladly work with your insurance to get the maximum benefit available to you. Most insurance plans do not cover 100% of your cost of treatment, therefore you will be asked to pay your deductible and co-payment for the charges on the day the services are rendered. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance. We will estimate your coverage - however, many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedure, and other restrictions). Therefore, we cannot guarantee any estimated co-payments. Your insurance coverage is an agreement between you and the insurance company – because of this, you are ultimately responsible for all charges. Please know that we will do everything we can to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.
- **We offer Compassionate Finance with flexible payment options.** You can apply online at www.compassionatefinance.com, or we are happy to help you with the application process to see what options are available to you.
- Payments 60 days past due are subject to a $50.00 late fee. Payments 90 days past due will be sent to collections.