Middletown Commons Family Dental

13301 Shelbyville Rd, Ste. 105 - Louisville, KY 40223 - (502) 631-9627

Patient Registration Form

Patient Information

Name: _____ **DOB:** _____ **Sex:** ( )M ( )F

Last First MI (Preferred)

Address: _____ **SS#:** _____

Street City State Zip

Please Mark One: ( )Single ( )Married ( ) Separated ( )Widow

Cell: _____ **Home:** _____ **Email:** _____

May we send appointment reminders via text or email for your convenience? **( ) Text ( )Email**

Employer Name: _____ Employer Phone: _____

How did you hear about us? _____ Check here if address is same for entire family **( ) Y**

(If someone referred you here, please write down their name so we can thank them.)

Emergency Contact Information

Name: _____ **Address:** _____

Cell: _____ **Work:** _____ **Relationship:** _____

Person Resonsible for account or parent (complete this section only if different from patient)

Guarantor Name: _____ **SS#:** _____ **DOB:** _____

Relationship: _____ **Phone:** _____

Employer: _____ **Employer Phone:** _____

Dental Insurance Information (Primary Carrier) **Relationship to Subscriber:** ( )Self ( )Spouse ( )Child

Insured's Name: _____ **SS#:** _____ **DOB:** _____

Insured's Employer: _____ **Insurance Co:** _____

Insurance Co Phone: _____ **Group Name:** _____ **Group #:** _____

Dental Insurance Information (Policy 2) **Relationship to Subscriber:** ( )Self ( )Spouse ( )Child

Insured's Name: _____ **SS#:** _____ **DOB:** _____

Insured's Employer: _____ **Insurance Co:** _____

Insurance Co Phone: _____ **Group Name:** _____ **Group #:** _____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, Mastercard, Visa, Discover, and American Express. We also offer extended payment plans and outside financing to provide affordable monthly payments for your happy and healthy smile.

Please check if you would like more information about financing options: ( )

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection agency/legal assistance, you will be responsible for any collection/legal charges up to 35%.

Do you have insurance?

- As a courtesy to you we will help you process all your dental insurance claims. Please understand that we will proide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance and plan benefits ultimately determine the amount paid.

-All charges you incur are your responsibility regardless of your insurance coverage. 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 payent regardless of what any insurance company's arbitrary determination of usual and customary rates.

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. I understand that responsibility for payment for dental services in this office fo rmyself 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 and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including mobile devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, or outgoing call to us, without reimbursement from us.

Patient Signature: _____ **Date:** _____

Patient's Name: _____ Date of Birth: _____
First Last

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:
- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____
City _____ State _____
Phone Number _____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐			
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐			
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐			
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO	
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐	Other _____
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐	
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?
_____
What medications are you currently taking?
_____
Family Physician Phone Number
_____

Consent:
The undersigned herby 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 have read, understand and agree to the above terms and conditions.

_____ _____ _____
Patient Signature (Parent if child) **Date** **Dentist Signature**