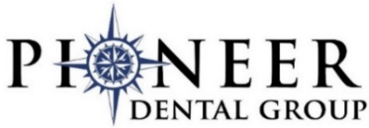


PATIENT REGISTRATION

First Name ______________________________ Last Name _________________________ Middle Initial ______

Preferred Name __________________________

Address: ________________________________ City: ______________________ State/Zip:_____________

Please select your preferred method of contact:

○ Home Ph: __________________ ○ Cell Ph: _______________ ○ Work Ph: _________________ ext: ________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Separated ○ Widowed ○ NA

Birth Date: _____________ Age: _______ Soc Sec #: ______________ Driver's Lic: _________

Email: _________________________________ Referred By: _______________________________

○ I would like to receive correspondences via email ○ I would like to receive confirmations via text message

○ I am interested in whitening my teeth ○ I am interested in a straighter smile

Emergency Contact: ___________________________ Emergency Ph.: _________________

Physician's Name: ____________________________ Physician's Ph.: _________________

Preferred Pharmacy: ___________________________ Pharmacy Ph.: ___________________

Employer: ________________________ Occupation: _____________________

Employment Status: ○ Full Time ○ Part Time ○ Retired Student Status: ○ Full Time ○ Part Time

Responsible Party (if someone other than the patient)

First Name: ______________________________ Last Name: ______________________ Middle Initial: ______

Address: _______________________________ City, State, & Zip: ______________________________

Home Ph.: ________________ Work Ph.: __________________ Ext: _______ Cell Ph.: _________________

Birthdate: ______________ Soc Sec #:_______________ Driver's Lic: _____________

○ Responsible Party is also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Primary Insurance Information:

Name of Insured: ________________________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: __________________ Insured Birth Date: ______________ Employer: ________________

Insurance Co: _____________________ ID #: _____________________ Group #: _____________________

Insurance Subscriber Address if different from patient: ____

Secondary Insurance Information:

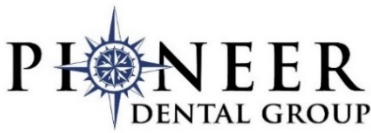
Name of Insured: ________________________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: __________________ Insured Birth Date: ______________ Employer: ________________

Insurance Co: _____________________ ID #: _____________________ Group #: _____________________

Insurance Subscriber Address if different from patient: ____

Patient or Guardian Signature: ____________________________________



FINANCIAL AGREEMENT

Our goal at Pioneer Dental Group is to provide our patients with the highest quality dental care possible while utilizing the highest quality materials, technology, and education tools available. Our financial policy is intended to facilitate excellent service while minimizing our administrative costs.

Our office strives to give our patients the most accurate estimate of their dental investment as possible and does expect full payment at the time of service. All charges you incur are your responsibility regardless of your insurance. As your dental care provider our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employers, and the insurance company. Our office is not a part of that contract. If payment from your insurance company has not been received within 60 days of the date of service you will be expected to pay the balance in full.

As a courtesy, our office will help to process all of your insurance claims. By signing below, you are authorizing your insurance company to pay your benefits directly to our office. In order for our office to file your insurance claims, you must bring a completed dental insurance form or proof of insurance at each appointment.

Our office accepts cash, personal checks, Mastercard, Visa, Discover, American Express, and offers payment plans through third party financing. If you would like more information regarding the third party financing please check with the financial coordinator.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month. (18% annually)

Our office scheduled your dental appointments carefully. Time, trained personnel and dental equipment are reserved for each procedure so we request that you give our office 48 hours' notice if you need to cancel or reschedule your appointment. **Cancellations are not taken via e-mail or voice mail. Missed appointments or late cancellations can be subjected to a $50.00 fee. There will be a $35 duplication fee applied for any unpaid radiographs should they be requested.**

Pioneer Dental Group is committed to providing you with the best experience in dental care so please do not hesitate to ask if you have any questions regarding our financial agreement.

____________________________________ __________________________

Print Name of Patient or Responsible Party Relationship

____________________________________ __________________________

Signature of Patient or Responsible Party Date

PIONEER DENTAL GROUP

MEDICAL HISTORY FORM

Patient Name (Please Print) ____ Birth Date ______________________

Although dental personnel primarily treat the area on and around your mouth, your mouth is a part of your entire body. Health problems that your may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Have you ever been hospitalized/had a major operation? Y N If yes, explain ________________________________
Have you ever had a serious head or neck injury? Y N If yes, explain ________________________________
Are you taking any medications, pills, or drugs*? Y N If yes, explain ________________________________
Do you take a pre-med antibiotic for dental treatment? Y N If yes, explain ________________________________
Do you take, or have you taken, Phen-Fen or Redux? Y N If yes, explain ________________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y N If yes, explain ________________________________
Are you on a special diet? Y N If yes, explain ________________________________
Do you use tobacco? Y N If yes, explain ________________________________
Do you drink alcohol? Y N If yes, how much:________________________________
Do you use controlled substances? Y N If yes, explain ________________________________
Are you interested in improving your smile? Y N If yes, explain ________________________________

WOMEN: Are you pregnant/trying to get pregnant? YES NO Est. Due Date: _________________ Nursing YES NO
Are you taking oral contraceptives? YES NO

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other NO KNOWN ALLERGIES

Please explain: ____

Do you have, or have you had, any of the following:

AIDS/HIV Positive	Y	N	**Chemotherapy**	Y	N	**Heart Murmur**	Y	N	**Lung Disease**	Y	N
Alzheimer's Disease	Y	N	**Chest Pains**	Y	N	**Heart Pacemaker**	Y	N	**Mitral Valve Prolapse**	Y	N
Angina	Y	N	**Cold Sores/Fever Blisters**	Y	N	**Heart Trouble/Disease**	Y	N	**Osteoporosis**	Y	N
Arthritis/Gout	Y	N	**Congenital Heart Disorder**	Y	N	**Hemophilia**	Y	N	**Pain in Jaw Joints**	Y	N
Artificial Heart Valve	Y	N	**Diabetes**	Y	N	**Hepatitis A**	Y	N	**Psychiatric Care**	Y	N
Artificial Joint	Y	N	**Drug Addiction**	Y	N	**Hepatitis B or C**	Y	N	**Radiation Treatments**	Y	N
Asthma	Y	N	**Easily Winded**	Y	N	**High Blood Pressure**	Y	N	**Renal Dialysis**	Y	N
Blood Disease	Y	N	**Emphysema**	Y	N	**Hypoglycemia**	Y	N	**Rheumatic Fever**	Y	N
Blood Transfusion	Y	N	**Epilepsy & Seizures**	Y	N	**Irregular Heartbeat**	Y	N	**Rheumatism**	Y	N
Breathing Problem	Y	N	**Excessive Bleeding**	Y	N	**Kidney Problems**	Y	N	**Sinus Trouble**	Y	N
Bruise Easily	Y	N	**Fainting /Dizziness**	Y	N	**Liver Disease**	Y	N	**Stroke**	Y	N
Cancer	Y	N	**Heart Attack/Failure**	Y	N	**Low Blood Pressure**	Y	N	**TB or Respiratory Disease**	Y	N

Have you ever had any serious illness not listed above? YES NO Explain: ____________________________________

**If you have any additional medications or conditions you may list them on the back of the form.*

Are you currently under the care of a physician or on a Pain Management Contract? YES NO

If yes, please provide the name and phone number of the physician or pain management clinic you are utilizing for treatment:

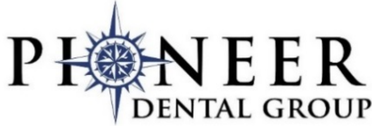
Physician: ___________________________________ Clinic: ______________________ Phone: ______________________

____ ____________________

Signature of Patient, Parent, Guardian Date

Doctor Signature: *Health History reviewed and electronically signed by Doctor*

LIST ADDITIONAL MEDICATIONS HERE:



PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal Law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Printed Patient Name:___________________________________ Date of Birth:_______________________

I have received a copy of the Privacy Notice of this organization on today's date.

Signed:____ Date:___________________________

Consent to Share

If you would like us to discuss your account or treatment plan with someone other than yourself, please indicate them below:

Release to:____ Personal Financial

Release to:____ Personal Financial

(OFFICE USE)

If patient is unable to acknowledge receipt, staff member providing notice needs to complete this section

Privacy Notice was provided to

Name:____________________________ Relation to Patient:____________________ Date:______________

Patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

____

____

Signed:____