PATIENT REGISTRATION

PATIENT INFORMATION Today's Date:

Patient Name _____ Nick Name _____ Date of Birth _____ Age ___
First Middle Last

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Domestic Partner ☐ Minor Child

Spouse/Domestic Partner/Parent Name _____ Phone _____

Sex: ☐ Male ☐ Female SSN # _____-_____-_____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

E-Mail _____ Whom may we thank for referring you? _____

Nearest relative not living with you & relationship _____ Phone _____

Primary Medical Doctor _____ Phone _____

Previous Dentist _____ Phone _____

Current or Former Orthodontist _____ Phone _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Current Employer _____ Bus. Phone _____

Occupation _____

Who will be responsible for this account? _____ Relationship to Patient _____

Billing Address _____ Phone _____

PHONE NUMBERS

Home ( ) _____ Work ( ) _____ Cell ( ) _____

IN CASE OF EMERGENCY, CONTACT _____ Phone ( ) _____
Name Relationship

DENTAL HISTORY

Reason for today's visit? _____ Date of last dental visit? _____

Date of last dental x-rays? _____ How often do you brush your teeth? _____ Floss your teeth? _____

Circle below if you have had any of the following:

Bad Breath	Bleeding gums	Blisters on lips/mouth	Burning sensation on tongue or lips
Chew on one side of mouth	Clicking or Popping jaw	Dry mouth	Grinding or clenching teeth
Gums swollen or tender	Loose teeth or broken fillings	Tooth sensitivity to cold	Tooth sensitivity to hot
Tooth sensitivity to sweets	Tooth sensitivity when biting	Jaw pain or tenderness	Mouth pain when brushing
Food collection between teeth	Mouth breather	Pain around ear	Sores/growths in mouth
Smoker (cigarette/cigar/pipe)	Chew tobacco	Yellow or discolored teeth	Orthodontic treatment
Periodontal treatment	Lip or cheek biting	Removable dental appliance	Difficulty opening/closing jaw
Recent infections or sore throat	Gum disease	Other? _____	

I acknowledge that the above information is accurate to the best of my knowledge.

X Signature of Patient (Parent or Guardian if a Minor) _____ **Date** _____

HEALTH HISTORY INFORMATION

Patient Name _____ Date _____

Health problems that you may have, or medications you are taking (including herbal or over-the-counter), could have an important impact on the care that you will receive and your oral health. Thank you for answering the following questions as accurately as possible.

Are you in good health? ☐ Yes ☐ No Any changes in your general health in the last year? ☐ Yes ☐ No If yes, explain: _____

_____

Yes	No	
☐	☐	Are you under the care of a physician? Physician's Name _____ Date of last visit? _____
☐	☐	Have you had a heart valve replacement or vascular graft? If yes, what and when? _____
☐	☐	Have you had a joint replacement? If yes, what area? _____ Month & Year done_____
☐	☐	Have you ever been advised by your physician to take "Pre-Medication" antibiotics prior to dental treatment?
☐	☐	Have you ever taken a bisphosphonate medication? (Bone density meds such as Fosamax, Actonel, Boniva, Atelvia, Didronel)
☐	☐	Have you ever taken any diet pill drugs referred to as "fen-phen" or similar (fenfluramine/phentermine) ? (Some common names are: Redux, Ionimin, Adipex, Fastin, Pondimin, and others)
☐	☐	Are you currently taking any blood thinner medications (such as Coumadin, Plavix, Aspirin, Xarelto, Eliquis, etc.)
☐	☐	Have you ever had any problems with general or local anesthesia? ☐ Yes ☐ No If yes, explain : _____

_____

For Women Only:

- Possibility of pregnancy? ☐ Yes, currently pregnant Due Date? _____ ☐ Possibly pregnant ☐ Not pregnant
- Are you currently nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Do you have, or have you had any of the following? Mark "Yes" or "No" to all diseases, medical conditions, or procedures.

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial Joints - where? _____	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Acid Reflux	☐	☐	Epilepsy	☐	☐	Low blood pressure
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Low blood sugar
☐	☐	Anemia	☐	☐	Eye Disease–specify _____	☐	☐	Mental Disorders
☐	☐	Anxiety	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse
☐	☐	Arthritis/Rheumatism	☐	☐	Heart Attack(s) - when? _____	☐	☐	Osteoporosis or Osteopenia
☐	☐	Asthma	☐	☐	Heart Disease - specify _____	☐	☐	Pneumonia
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Respiratory problems
☐	☐	Blood Transfusion	☐	☐	Heart Surgery - when? _____	☐	☐	Rheumatic Fever
☐	☐	Bronchitis/Chronic Cough	☐	☐	Headaches	☐	☐	Scarlet Fever
☐	☐	Bruise easily	☐	☐	Hepatitis - type? _____	☐	☐	Sexually transmitted disease
☐	☐	Cardiac Pacemaker	☐	☐	Herpes	☐	☐	Sinus problems
☐	☐	Cancer – type _____	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea/Use a CPAP
☐	☐	Chemotherapy	☐	☐	HIV	☐	☐	Smoker-cigarettes, pipe, cigar?
☐	☐	Chemical Dependency – drugs/alcohol	☐	☐	Immune System Problems	☐	☐	Snoring
☐	☐	Diabetes-type _____	☐	☐	Jaw Pain/Clicking/Popping	☐	☐	Stroke
☐	☐	Difficulty Breathing	☐	☐	Jaundice	☐	☐	Thyroid Disease
☐	☐	Dizziness or Fainting	☐	☐	Kidney Disease	☐	☐	Tuberculosis
						☐	☐	Ulcers - type? _____
						☐	☐	Use chewing tobacco

Any other medical condition not listed above?

_____

ALLERGIES

Do you have allergies or sensitivities to any of the following?

Yes	No		Yes	No	
☐	☐	Penicillin drugs	☐	☐	Local Anesthetic
☐	☐	Sulfa drugs	☐	☐	Latex
☐	☐	Erythromycin drugs	☐	☐	Metals
☐	☐	Other Antibiotics	☐	☐	Any other drugs?
☐	☐	Codeine			Specify_____
☐	☐	Aspirin	☐	☐	Any other substances?
☐	☐	NSAIDS			Specify_____

*Non-steroidal anti-inflammatories

MEDICATIONS

Please list all medications, including herbal supplements & over the counter meds you are currently taking and dosage or provide a copy of your meds list:

Medication **Dosage**

_____

_____

_____

_____

_____

I certify that all of my health information is complete and accurate to the best of my knowledge. I understand that if there is a change in my health or medication(s) during my dental treatment, I am responsible for updating Maryam Jackson, D.D.S. and/or her Staff as to those changes.

Patient Signature _____ **Date** _____

DENTAL INSURANCE INFORMATION (Please complete only if you have dental insurance)

Patient Name_____ D.O.B. _____ Relationship to Insured _____

Is patient covered under more than one dental plan? ☐ Yes ☐ No (If Yes, complete Secondary Insurance Information Section also)

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Domestic Partner ☐ Minor Child

Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable

School Info: _____
Name of School School Address City State Zip

Primary Dental Insurance Plan

Insurance Co. Name _____

Group Name _____ Group # _____

Subscriber Name _____

Subscriber ID or SSN _____

Subscriber D.O.B. _____ Relationship to Pt. _____

Employer _____

Employer Address _____

_____

Employer Phone ( ) _____

Secondary Dental Insurance Plan

Insurance Co. Name _____

Group Name _____ Group # _____

Subscriber Name _____

Subscriber ID or SSN _____

Subscriber D.O.B. _____ Relationship to Pt. _____

Employer _____

Employer Address _____

_____

Employer Phone ( ) _____

INSURANCE ASSIGNMENT of BENEFITS and PATIENT INSURANCE FINANCIAL POLICY

I certify that I, and/or my dependents have insurance coverage with _____
Name of Insurance Company (ies)

I agree to assign all insurance benefits, otherwise payable to me for services rendered, directly to Dr. Maryam Jackson, D.D.S. I understand that I am financially responsible for all charges, whether or not paid by my insurance. This signature on file is my authorization for the release of information necessary to process my claims.

X Signature of Patient (Parent or Guardian if a Minor) _____Date_____

Please understand that your insurance plan is a contract between you and your insurance company. We will gladly complete and submit any claims for services rendered by this Office as a courtesy. Please familiarize yourself with your plan benefits. Not all plans are the same. Some may pay a fixed plan allowance for a procedure, while others may pay based on a percentage of the fee charged, and everything in between! Most plans have a variety of limitations, exclusions, frequency allowances, etc. It is your responsibility to pay any applicable deductible amount, co-insurance, or any other balance not paid by your insurance company at the time the services are rendered. Your signature below acknowledges your understanding and agreement of this policy.

X Signature of Patient (Parent or Guardian if a Minor) _____Date_____

Maryam Jackson, D.D.S.

743 E. Chapman Avenue **Orange, CA 92866** **(714) 997-5495** **smilesoforange743@gmail.com**

Patient Name: _____ Date: _____

Please read and initial where indicated.

Patient Acknowledgements

A. I have received a detailed copy of the ***Notice of Privacy Practices*** written in plain language from the office of ***Maryam Jackson, D.D.S.*** The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains.

Initials

B. I have received a copy of the ***Dental Materials Fact Sheet*** dated May 2004, as required by law. This fact sheet contains a summary of information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

Initials

Office Financial Policy

We are committed to the successful completion of your proposed treatment and look forward to a lasting professional relationship . It is important to us that clear communication of our Financial Policy is established from the beginning. Please review the following guidelines. If you have any questions regarding these guidelines, or our fees, we would gladly discuss them with you in more detail. We ask that payment be made at the time of service. If applicable, we are happy to bill your dental insurance plan(s) for covered services and wait for their approved portion of reimbursement to us, however, any insurance estimated co-payments, deductibles, non-covered services, etc., will be collected at the time of service. Any other financial arrangement must be discussed with our Office Manager in advance of services performed.

We accept the following methods of payment:

- Cash or Personal Check
- Debit Cards
- Visa, MasterCard and Discover
- Care Credit (3rd party Healthcare Financing—ask our Office Manager for details)

Initials

I understand and will abide by this Office's Financial Policy as stated above.

Appointment Cancellation Policy

Last minute cancellations or missed appointments are costly to everyone! We understand that things come up from time to time that may prevent you from keeping your scheduled appointment. We appreciate your consideration in providing at least **48 business hours'** notice when needing to cancel or reschedule an appointment to avoid a $75.00 Cancellation Fee. Please keep in mind that we do not have office hours on Fridays, Saturdays, or Sundays, and will not be made aware of your need to change an appointment until Monday morning if you have only left a voice message after office hours. Please contact our office during normal business hours if you need to change an appointment. Our Office hours are: Monday, Tuesday, and Wednesday 8:30--5:30PM, Thursday 8:30-2:30PM. Confirmed appointment "No Shows" will also be subject to a Cancellation Fee. We can help keep you on track with convenient text, email, or telephone appointment reminders. Please ask our Business Office to set up your appointment reminder preferences.

Initials

I understand and will abide by this Office's Appointment Cancellation Policy as stated above.

Insurance

If applicable, your insurance coverage is a contract between you and your insurance company or employer. As a courtesy, we will gladly bill your insurance company for any covered services. Estimated co-payments, deductibles, etc., if any, will be requested at the time of service. Your initials here authorize us to release any pertinent information to your insurance carrier, which may be required for the accurate processing of your dental claims.

Initials

I understand and will abide by this Office's Insurance Policy as stated above.