PATIENT REGISTRATION

First Name_____ Last Name_____ MI_____

Birth Date_____ Social Security_____

Address_____

City, State, Zip_____

Email_____

Home Phone_____ Work Phone_____

Cell Phone_____

Emergency Contact Name_____ Number_____

Relationship_____

If your number or address changes PLEASE notify us as soon as possible.

Employer:_____

Address:_____

Phone Number:_____

Insurance Information

If you have a Provider One services card, please list the I D number _____

Name of Insurance Company _____

Employer Name and Address_____

Insurance I D number_____

Insurance Group number_____

Insurance Address_____

NO SHOW / CANCEL SHORT NOTICE

Initial_____ Failure to cancel your appointment within 24 hours may result in a $53 fee.

Initial_____ Failure to show up to your appointment may result in a $53 fee.

Initial_____ 2 failed appointments will result in a dismissal from our office.

Initial_____ IF WE ARE UNABLE TO CONFIRM YOUR APPOINTMENT BY PHONE IT MAY BE MOVED OR CANCELED.

Name of Physician/and their specialty:_____

Most recent physical examination: _____Purpose: _____Recent Height: _____ Weight: _____

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

Do you need an Antibiotic Pre-Medications for dental treatment? □Yes Please list: _____ □No

Do you receive pain medication from your primary physician? □Yes □No If yes what:_____

How often:_____ Prescriber:_____

Failure to inform us of medication can result in us denying prescriptions.

An allergic Reaction to:

□ Aspirin
□ Sulfa
□ Latex
□ Penicillin
□ Local Anesthetic
□ Ibuprofen
□ Erythromycin
□ Fluoride
□ Acetaminophen
□Tetracycline
□ Metals (Nickel, Gold, Silver)
□ Codeine

Do you have or have you ever had Y-Yes, N-NO:

□ Y □ N Hospitalizations for illness or injury
□ Y □ N Anemia or other blood disorder
□ Y □ N Thyroid, parathyroid disease, or calcium deficiency
□ Y □ N Contact lenses
□ Y □ N HIV/AIDS
□ Y □ N Heart problems, or cardiac stent within the last six months
□ Y □ N Prolonged bleeding due to a slight cut (INR>3.5)
□ Y □ N Hormone Deficiency
□ Y □ N Head or neck injuries
□ Y □ N Tumor, abnormal growth
□ Y □ N History of infective endocarditis
□ Y □ N Emphysema, Sarcoidosis
□ Y □ N High cholesterol or taking statin drugs
□ Y □ N Epilepsy, convulsions (seizures)
□ Y □ N Artificial heart valve, repaired heart defect (PFO)
□ Y □ N Tuberculosis
□ Y □ N Diabetes (HbA1c=_____)
□ Y □ N Neurologic problems (attention deficit disorder)
□ Y □ N Chemotherapy
□ Y □ N Pacemaker or implantable defibrillator
□ Y □ N Asthma
□ Y □ N Stomach or duodenal ulcer
□ Y □ N Viral infections and cold sores
□ Y □ N Emotional problems
□ Y □ N Artificial prosthesis (heart valve or joints)
□ Y □ N Breathing or sleep problems (i.e. snoring)
□ Y □ N Digestive disorders (i.e. gastric reflux)
□ Y □ N Any lumps or swelling in the mouth
□ Y □ N Psychiatric treatment
□ Y □ N Radiation therapy
Other:_____
□ Y □ N Rheumatic or scarlet fever
□ Y □ N Kidney Disease
□ Y □ N Osteoporosis/osteopenia (i.e. taking bisphosphonates)
□ Y □ N Hives, skin rash, hay fever
□ Y □ N Antidepressant Medication
□ Y □ N High or low blood pressure
□ Y □ N Liver Disease
□ Y □ N Arthritis
□ Y □ N STI/STD
□ Y □ N Alcohol/street drug use
□ Y □ N Stroke (taking blood thinners)
□ Y □ N Jaundice
□ Y □ N Glaucoma
□ Y □ N Hepatitis (Type_____)

Are you:

□ Presently being treated for any other illness
□ Taking dietary supplements
□ A smoker, smoked previously or use smokeless tobacco
□ FEMALE- Taking birth control
□ Aware of a change in your health (i.e. fever, new cough)
□ Often exhausted or fatigued
□ Considered a touchy person
□ FEMALE- Pregnant
□ Taking medication for weight management (i.e. fen-phen)
□ Experiencing frequent headaches
□ Often unhappy or depressed
□ MALE- Prostate Disorder

Describe any current treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment._____
_____

List all medications, supplements, and or vitamins taken within the last two years and their purpose (Or bring list in):
_____
_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Signature of Patient, Parent or Guardian: _____ **Signature of Doctor** _____

DENTAL HISTORY

Previous Dentist_____
For how long?_____

Please circle your answer:
When was your last dental exam? 1-3 months 4-6 months 6-12 months 1-2 years 2+ years

How often do you have your teeth cleaned? *Every:* 3 months 4 months 6 months 1 year or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Yes No Are you self-conscious of your teeth and/or smile?
Yes No Do you like the color of your teeth?
Yes No Do you have spaces between your teeth that bother you?
Yes No Do you have chips or uneven edges on your teeth?
Yes No Do you feel that your teeth are too long or too short?
Yes No Do you have dark fillings that show when you smile?
Yes No Do you avoid brushing any part of your mouth?
Yes No Is any part of your mouth sensitive to temperature?
Yes No Do you have sore teeth?
Yes No Any burning sensation in your mouth?
Yes No Bleeding gums?
Yes No Difficulty swallowing?
Yes No Any unpleasant taste or odor in your mouth?
Yes No Dry mouth, throat and/or eyes?
Yes No Jaw problems (temporomandibular joint)

Yes No Do you have difficulty opening your mouth widely?
Yes No Stiff neck muscles
Yes No Tension headaches
Yes No Do you clench or grind your teeth?
Yes No Do you experience jaw clicking or popping?
Yes No Have you lost any teeth?
Yes No Have you had an unfavorable dental experience?
Yes No Do you have dental fears?
Yes No Problems with effectiveness or bad reactions to dental anesthetic
Yes No Have you had periodontal (gum) treatment? If yes, when? _____
Yes No Have you had orthodontic treatment (braces) If yes, when?_____
Yes No Do you sweat or tremble a lot during an exam?
Yes No Do strange/unknown people or places make you afraid?

Is there anything else that you would like us to be aware of regarding your oral health?_____
_____
What sports do you participate in?_____
Where do you get your water supply from?_____City_____Own well_____Bottled

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:
Has your present denture been relined? When_____
Is your present denture a problem? Explain_____
Satisfied with the appearance?____ Satisfied with the comfort?____ Satisfied with the chewing ability?____
When did you receive your first partial or complete denture?_____
How long have you worn your present denture?_____

PATIENT'S SIGNATURE_____DATE_____

DOCTOR'S SIGNATURE _____DATE_____

ENHANCED DENTAL CARE

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our General Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, etc.)

ACKNOWLEDGEMENT OF RECEIIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the STATEMENT OF PRIVACY PRACTICES for Enhanced Dental Care, the office of Dr. Jonathan Gantz, DDS. The STATEMENT OF PRIVACY PRACTICES describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The STATEMENT OF PRIVACY PRACTICES also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The STATEMENT OF PRIVACY PRACTICES is also posted in the facility.

Enhanced Dental Care reserves the right to change the privacy practices that are described in the STATEMENT OF PRIVACY PRACTICES. If privacy practices change, I will be offered a copy of the revised STATEMENT OF PRIVACY PRACTICES at the time of my first visit after the revisions become effective. I may also obtain a revised STATEMENT OF PRIVACY PRACTICES by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY
In addition to the allowable disclosures describes in the STATEMENT OF PRIVACY PRACTICES, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

SPOUSE ONLY:_____ _____YES _____NO

ANY MEMBER OF MY IMMEDIATE FAMILY: _____YES _____NO

Family Members Name:_____

Relationship:_____

Family Members Name:_____

Relationship:_____

OTHER (PLEASE SPECIFY): _____YES _____NO

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____
Patient, Parent, or legal Guardian Date

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, etc.)

(**OFFICE USE ONLY)**

Provided prior to treatment ____Yes ____No
Reason for Denial:
____Needed more time to review statement of privacy practices
____Wanted to consult with another person before signing
____Unable to sign
____Reason not given
____Other (explain):_____

FINANCIAL OPTIONS

In order to provide you with the highest quality dental care, we offer our patients a variety of payment options. By establishing a clearly defined method of payment, we hope to eliminate confusion, simplify insurance claims, and provide more thorough coverage for our patients.
So that we will both have a definite understanding, please select the payment plan that is most appropriate for you.

1. **CASH or CHECK**

2. **MAJOR CREDIT CARDS**
   We accept Visa, Master Card, Discover, & American Express.

3. **EXTENDED PAYMENT PLAN (PROFESSIONAL LENDING INST.)**
   Extended monthly payments based on credit approval with CareCredit or GESA Life Loans

You are directly responsible to us for payment of treatment. As a courtesy, we accept assignment of benefit payments from your insurance company. This will reduce your immediate out-of-pocket expenditures. We will do our utmost to help you derive the maximum benefits to which you are entitled.

The insurance estimates we give you are based on limited information obtained from your insurance company. If we need more detailed information on your benefits in order to file your claim, you will need to provide that to us.

Insurance companies calculate their payment on the contract signed with your employer, not on the doctor's fees.

This office will not file an insurance claim which falsifies dates of treatment, fees charged, treatment performed, or any other information.

We realize that emergencies can occur. Should an unforeseen situation prevent you from making a pre-arranged payment, please contact our office to avoid the possibility of a misunderstanding.

Please help us serve you and our other patients better by keeping scheduled appointments.
Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments.

Failure to cancel your appointment within 24 hours may result in a $53.00 fee.
Failure to show up to your appointment will result in a $53.00 fee.
2 failed appointments will result in a dismissal from our office FOR TWO YEARS.
IF WE ARE UNALBE TO CONFIRM YOUR APPOINTMENT BY PHONE, YOUR APPOINTMENT CAN BE MOVED OR CANCELED.

Thank you for taking the time to read and understand our financial options. Please feel free to ask any questions you may have. We look forward to providing you with the highest level of professional care.

_____

Patient Signature of Acknowledgement