

NEW PATIENT REGISTRATION

Thank you for choosing our office!

Please take a few moments to complete our short new patient registration form.

Appointment date and time Location

First name Last name Date of birth

Phone number Email

Street address Apt / unit

City State Zip code

How did you hear about us?

If through a friend or family member, please choose 'Other' and provide their full name.

My insurance

Online search

Other: _____

DENTAL HISTORY 1/3

What service(s) are you interested in?

Check all that apply

- Check up and cleaning, no other concerns
- Check up and cleaning, light concerns
- Check up and cleaning, advanced concerns
- Invisalign
- Veneers
- Implants / tooth replacement
- Wisdom teeth issues
- Whitening
- Dental emergency
- Sleep apnea / snoring - We offer highly predictable oral appliance solutions which are often covered by medical insurance.
- Other: _____

Please add any specific questions or concerns you would like addressed at your first visit.

DENTAL HISTORY 2/3

Who was your last dentist?

Name

Location

When was the last time you saw a dentist?

- less than 6 months over 2 years
- 6-12 months over 5 years
- over a year

Why did you decide to change dentists?

Have you ever had an unpleasant dental experience?

- Yes No

If yes, please describe below. We want to make sure it does not happen again!

DENTAL HISTORY 3/3

How is your dental health?

- Good Needs improvement
 Average Not sure

Do your gums bleed when you brush or floss?

- Never
 Sometimes
 Almost every time

Are you interested in cosmetic options?

- Yes No

If yes, please describe:

MEDICAL HISTORY 1/2

Are you currently under a physician's care?

- Yes No

If yes, what is the purpose of the current care being provided?

If yes, what is your physician's name and phone number?

Name

Phone number

Have you ever had or do you currently have any of the following conditions?

Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Snoring / sleep apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> none of the above |

Are you allergic or have you had a bad reaction to any of the following?

Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetic (novocaine) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> none of the above |

MEDICAL HISTORY 2/2

Has a physician or dentist ever recommended you pre-medicate with antibiotics before dental treatment?

Yes

No

What medications if any are you taking right now and for what condition?

Include prescription and over the counter, for example: Prilosec for acid reflux

Any other medical conditions or allergies, please describe:

Female patients, are you:

Pregnant

Nursing

INSURANCE DETAILS

Do you have dental insurance you would like to use for this appointment?

- Yes, I already provided the information when I requested an appointment
- Yes, I still need to provide my insurance information
- No

Do you know what type of coverage you have?

- PPO HMO Not sure

Insurance carrier: _____

Insurance carrier phone number: _____

Group number: _____

Identification number: _____

This may be your social security number

What is your relationship to the subscriber?

- I am the subscriber Spouse Child

INSURANCE SUBSCRIBER DETAILS

Only complete if you are not the subscriber

First name

Last name

Date of birth

Subscriber social security number: _____

OFFICE POLICY ACKNOWLEDGMENT

Patient Feedback!

After every appointment, you will receive a short follow up via text or email about your visit. We pay very close attention to any feedback. Feedback is used to recognize employees for excellent performance and identify any area where we may improve our service. Please be perfectly honest with any feedback, we really want to hear how your visit went with us.

Referral Rewards Program!

The program is simple - for every referral you send to our office, we will give you a \$25 credit to your account. Make sure you get credit for everyone you refer! Credits are processed at the beginning of every month.

Cancellation Policy

When we reserve time for your appointment, we make room in our schedule so we may devote our time and focus our efforts on serving your needs. Late cancellations mean we have empty time in our schedule when we could have been helping another patient.

There is a \$25 charge for reserved appointments broken or changed without 24 hours notice for weekday (Mon-Fri) dental appointments.

There is a \$100 per hour charge for reserved appointments broken or changed without 48 hours notice for weekend (Sat-Sun) dental treatment appointments with a dentist.

There is a \$50 per hour charge for reserved appointments broken or changed without 48 hours notice for weekend (Sat-Sun) dental treatment appointments with a dental hygienist.

Financial & Privacy Policies 1/2

You are responsible for the total fee for services performed at this office. Cash and all major credit cards are accepted as payment for services. Checks are not accepted.

If you have insurance, we will provide an estimate of what we think your insurance company will probably pay and collect the difference from you at the time of service.

If you have insurance, we are obligated to bill your insurance for all procedures completed on your behalf. Cosmetic procedures may not be billed to insurance.

If the insurance company pays more than we expected, you will have a credit on your account. We will mail you a statement informing you of the credit. You may keep it on your account or we can refund it to you. All outstanding insurance claims must be received before we may issue any refunds.

If the insurance company pays less than we expected or not at all, you are responsible for the difference between what you have already paid and your total fee.

Financial & Privacy Policies 2/2

We will try to arrange payment from your insurance company for a maximum of 45 days. After 45 days, you are responsible for any balance on your account, regardless of whether your insurance company has paid us or not.

If we receive payment after 45 days from your insurance company, it will be applied to your account and you will receive a statement from us informing you of any credit generated by the payment.

After 75 days from the date of service, any unpaid balance will be turned over to a collection agency. This is our standard policy for all delinquent accounts. Once an account is sent to collections, you must pay the collection agency. You will no longer be able to pay us directly for the balance.

In accordance with HIPAA, I understand that I am giving my full permission to this office to use and disclose my protected health information in order to carry out treatment, payment activities and healthcare operations. I understand I have the right to revoke permission. I understand that my insurance company will send payment directly to the office unless prior arrangements have been made.

Independent Dentist Services

I understand that the dentist(s) providing services to me at this location (Dental Salon Chicago, LLC, Dental Salon Schaumburg, LLC, Mesa Dental Arizona, LLC DBA Southern Dental Arizona, Superstition Springs Dental, Beck Commons Dental Care, PLLC), such as my personal dentist (s) and dental specialists, are independent contractors and are not employees of this location. They are covered under their own liability insurance which is separate and unrelated to this location. My decision to seek dental care at this location is not based on any understanding, representation, advertisement, media campaign, inference, implication or reliance that the dentists who are or will be treating me are employees or agents of this location.

Video and Audio Recording

Video and audio recording devices are used throughout the office to ensure a high quality experience for all of our patients. These recordings may be used for training purposes.

Parking

We offer discounted validated parking in the garage attached to the building at our Chicago location. We have no control over what the parking garage charges.

Parking at the Schaumburg, Mesa, Phoenix and Round Rock locations is available for free in the lots in front of the building.

I have read, understand and acknowledge receipt of these office policies.

Signature

Date

Print name

2019

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