PATIENT REGISTRATION

First Name: ______________________________ Last Name: ________________________ Preferred Name: ___________________

Responsible Party (parent/guardian if minor)

First Name: ________________________ Last Name: __________________________ Middle Initial: ____

Address: ____ Address 2:________________________________

City, State, Zip: ____Home Phone: _________ ______________________

Name of Employer: __________________ Work Phone: __________________ Ext: _________ Cellular: __________________

Birth Date: _______________ Soc. Sec. _____________________ Driver Lic: ____________________

( ) Responsible Party is also a Policy Holder for Patient

Patient Information

Address: ____ Address: ______________________________

City: _______________________________ State/Zip: _______________________ Home Phone: ____________________

Name of Employer:______________________ Work Phone: _________________ Ext: ___________ Cellular: ____________

Sex: ( ) Male ( ) Female Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Birth Date: _______________ Age: ________ Soc. Sec. _____________________ Drivers Lic: ______________________

E-mail: ____ ( ) I would like to receive correspondences via e-mail.

Employment Status: ( ) Full Time ( ) Part Time ( ) Retired Student Status: ( ) Full Time ( ) Part Time

In order to maximize your insurance benefits to the fullest, please complete the following if card not provided:

Primary Insurance Information

Name of Insured: _______________________________ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec. _______________________________ Insured Birth Date: __________________________

Employer: ___________________________________ Insurance Company: _____________________________ Group #: _________

Secondary Insurance Information

Name of Insured: _____________________________ Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Soc. Sec: _____________________________ Insured Birth Date: ____________________

Employer: __________________________________ Insurance Company: _____________________________ Group #: ________

Emergency Contact

Name: _______________________________________ Home/Cell Phone: ____________________________

Relationship: __________________________________ Work Phone: ____________________________

DENTAL HISTORY

Date of Last Dental Visit: ______________________

1. How often you brush your teeth? __________________
2. Do your gums bleed while brushing or flossing? ( ) Yes ( ) No
3. Are you currently experiencing any pain? ( ) Yes ( ) No
4. Are your teeth sensitive to hot or cold? ( ) Yes ( ) No
5. Are your teeth sensitive to sweet or sour? ( ) Yes ( ) No
6. Do you wear dentures or partials? ( ) Yes ( ) No
7. How would you rate your smile? ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
8. Is anything you want to change about your smile? ( ) Yes ( ) No If yes, please explain: ____________________

MEDICAL HISTORY

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

Physician Name: ______________________________ Office Phone Number: (______) _________________

Are you under physician's care now? ( ) Yes ( ) No If yes, please explain: ________________________
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No If yes, please explain: ________________________
Have you ever had a serious head or neck injury? ( ) Yes ( ) No If yes, please explain: ________________________
Are you taking any medications, pills, or drugs? ( ) Yes ( ) No If yes, please explain: ________________________
Do you take, or have you taken Phen-Fen or Redux? ( ) Yes ( ) No ________________________
Are you on a special diet? ( ) Yes ( ) No ________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ( ) Yes ( ) No ________________________
Do you use tobacco? ( ) Yes ( ) No ________________________
Do you use controlled substances? ( ) Yes ( ) No ________________________

Women: ( ) Pregnant/Trying to get pregnant? ( ) Nursing? ( ) Taking oral contraceptives?

Are you allergic to any of the following? ( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics

( ) Other: Please explain: ____
Are you taking any of blood thinner medications?
If yes, please explain: ____

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

( ) AIDS/HIV Positive
( ) Alzheimer's Disease
( ) Anaphylaxis
( ) Anemia
( ) Angina
( ) Arthritis/Gout
( ) Artificial Heart Valve
( ) Artificial Joint
( ) Asthma
( ) Blood Disease
( ) Blood Transfusion
( ) Breathing Problems
( ) Bruise Easily
( ) Cancer
( ) Chemotherapy
( ) Chest Pains
( ) Cold Sores/Fever Blisters
( ) Congenital Heart Disorder
( ) Convulsions
( ) Diabetes
( ) Drug Addiction
( ) Emphysema
( ) Epilepsy/Seizures
( ) Excessive Bleeding
( ) Fainting Spell/Dizziness
( ) Frequent Headaches
( ) Leukemia
( ) Genital Herpes
( ) Glaucoma
( ) Hay Fever
( ) Heart Attack/Failure
( ) Heart Murmur
( ) Hemophilia
( ) Heart Pace Maker
( ) Hepatitis A
( ) Hepatitis B or C
( ) Herpes
( ) High Blood Pressure
( ) Hives or Rash
( ) Irregular Heartbeat
( ) Kidney Problems
( ) Stomach/Intestinal Disease
( ) Liver Disease
( ) Low Blood Pressure
( ) Lung Disease
( ) Mitral Valve Prolapse
( ) Osteoporosis
( ) Osteopenia
( ) Pain in Jaw Joint
( ) Parathyroid Disease
( ) Psychiatric Care
( ) Radiation Treatments
( ) Renal Disease
( ) Rheumatic Fever
( ) Rheumatic Fever
( ) Rheumatism
( ) Scarlett Fever
( ) Shingles
( ) Sickle Cell Disease
( ) Stroke
( ) Swelling of Limbs
( ) Thyroid Disease
( ) Tonsillitis
( ) Tuberculosis
( ) Ulcers
( ) Venereal Disease
( ) Yellow Jaundice
( ) Recent Weight Loss

Have you ever had any serious illness not listed above? If yes, please explain: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____ ____________________

Signature of Patient (Legal Guardian, if Minor) Date

____ ____________________

Doctor's Signature Date

ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had full opportunity to read, understand the contents, and am aware I may have a copy of this office's Notice of Privacy Practices upon request. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information to carry out all payment activities and health care operations.

AUTHORIZATION FOR COMMUNICATION

I authorize Pure Zen Dentistry to release the following information about my health care (please check all that apply):

□ Any and all information
□ Information necessary to schedule, confirm, cancel, or reschedule appointments
□ Information about prescriptions
□ Information about my bills or account
□ I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name: Relationship to the Patient:

_________________________________ _________________________________

_________________________________ _________________________________

□ I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.

FINANCIAL POLICY

We feel that all patients deserve from us the very dental care we can provide. Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

INSURANCE

While the filing of commercial insurance is a courtesy that we extend to our patients, all charges for services and materials are your responsibility from the date services are rendered, unless our office has a contractual agreement with your dental plan prohibiting a portion of the charges. In this instance you will be responsible for all charges up to the contracted fee. A 45-day grace period will be allowed for insurance payment, provided co-payments are made at time of service. Prepayment of services may be required for extensive treatments plans.

Commercial insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our fees reflect our services, not an insurance company's reimbursement schedule. Certain insurance companies may choose not to pay your dental fee in full. This is not uncommon and is unfortunate for those affected by this problem. If your insurance company selects a level of reimbursement (an arbitrary value sometimes referred to as "usual and customary") which is below our standard fees, the responsibility of the remaining balance is placed on you when applicable. The payment schedule will be based upon the estimated benefit coverage provided by your insurance company.

Should your insurance company choose not to accept Assignment of Benefits (An arrangement by which a patient requests that their health benefit payments be made directly to the provider) payment in full will be due at time of service. As a courtesy to you, however, our office will still file the insurance claim on your behalf for direct reimbursement.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless prepayment has been made for serviced to be rendered.

CANCELLATION POLICY

We do understand that illness, emergencies, flat tires, and bad weather happen. We ask our patients to give us a minimum 24 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy.

· Cancellation or rescheduling of an appointment with 24 hours or more notification will result in no charge. A failed appointment is an appointment that is cancelled/rescheduled without 24 hours' notice or an appointment where a patient does not show up.
· We do allow for one (1) broken appointment as a courtesy.
· Any additional failed appointments will be charged a fee of $25.
· After two (2) failed appointments, we may require a deposit of up to 100% that will be applied to your appointment, in order to reserve any further appointments.
· After three (3) failed appointments you risk being dismissed from the practice.

NSF CHECKS

All checks returned for non-sufficient funds will incur a $35.00 service fee.

DELINQUENT ACCOUNTS

Should the account become delinquent (past 45 days), the patient (parent/guardian if patient is a minor), will be responsible for all collection costs including agency fees, attorney fees, court fees, or any other fees incurred to collect this debt.

AUTHORIZATION AND RELEASE

I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to the Dentist or Practice, insurance benefits otherwise payable to me.

I have read and agree to the above financial policy and acknowledgment of privacy practices.

x____ ____
Signature of patient (Parent/Guardian if minor) Date

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

During your course of treatment, the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. In the state of Indiana a dental hygienist ***cannot*** diagnosis a patient.

- **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

- **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dental hygienist and dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning below the gum line, placement of an antibiotic below the gum line or a gross debridement (two part cleaning). If further treatment such as gum surgery and/or extractions are necessary a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends on your efforts to brush, floss daily, receive scheduled periodontal treatments and maintenance, follow a healthy diet, avoid tobacco products and follow any other recommendations of our staff. Some bleeding after scaling and root planing can occur, however, should it persist and if it is severe in nature the office should be contacted. Untreated periodontal disease can have future adverse effects on the long term success of dental treatment and can also lead to tooth loss.

- **RESTORATIONS (FILLINGS)** A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown or both. Sensitivity is a common post-operative symptom of a newly placed restoration. Occasionally after receiving a restoration it may feel high and you may need to return to have the bite adjusted.

CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

ALLERGIES/MEDICATION I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

CONSENT I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

____

Patient Name

____ __________

Patient or Parent/ Legal Guardian Signature Date