MILLENNIUM
DENTAL

PATIENT REGISTRATION:

PATIENT NAME: _____

Please Circle: MALE / FEMALE _____ **Date of Birth:** _____

SOCIAL SECURITY NUMBER: _____ **DL #:** _____

Home Address: _____ **City:** _____ **Zip Code:** _____

Best Phone Number to reach you during Daytime/ Business Hours: _____

Home #: _____ Work #: _____ Cell #: _____

E-mail Address: _____

Referred by: _____ Marital Status: _____

Emergency Contact Name: _____ Phone Number: _____

Minors ONLY:

Person Financially Responsible: _____ Relationship: _____

Phone Number: _____

Do you have Dental Insurance? Y / N

Dental Insurance Company: _____ Phone Number: _____

Claims Mailing Address: _____

Subscribers Name: _____ Subscribers DOB: _____

Subscribers ID or SSN: _____ Patient Relationship to Subscriber: _____

Group Number: _____ Subscriber Employer: _____

What are your Primary Concerns for Today's Visit? (Please check all that apply)

- ○ Routine Cleaning and Exam/ General Health
- ○ Gum/Periodontal Disease
- ○ Oral Cancer
- ○ Cavities
- ○ Broken Teeth
- ○ Appearance
- ○ Bad Breath
- ○ Other: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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MEDICAL HISTORY:

PATIENT NAME: _____ **DOB:** _____

- **Are you currently under the care of a physician for reasons other than routine medical?** Y / N
  If Yes, Physician's Name and Phone Number: _____
  _____

- **Are you allergic to any of the following?** (If Yes, please circle)
  Penicillin Latex Sulfa Codeine Other: _____

- **Have you ever had any of the following?** (If Yes, please circle)
  Chemotherapy Radiation Joint Replacement Heart Murmur or
  Been told you need premedication for dental appointments? _____

- **Have you taken any bone building medication?** _____
  _____

- **Do you use or have you ever used any tobacco products?** Y / N
  (If Yes, please circle) Smoke / Smokeless / Vape

- **WOMEN ONLY: Are you currently pregnant?** Y / N (If Yes, how many weeks?) _____

- **Please list all your surgeries and date of surgery:**

	SURGERY:	**DATES:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

- **Please list all your present medication and reason why you are taking medication**

	MEDICATION:	**REASON:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

Is there anything else in your medical history we should know about? _____
_____

PATIENT SIGNATURE: _____ **DATE:** _____

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DENTAL HISTORY:

PATIENT NAME: _____ **DOB:** _____

- If needed, can we contact your previous dentist for your dental records? Y/N
  If Yes, what's the dentist's name and phone number? _____
  _____
- Do your gums bleed when you brush or floss? Y/N
- Are your teeth sensitive to: (Please circle)
  Cold Hot Sweets Pressure
- Does food or floss get caught between your teeth? Y/N
- Do you experience dry mouth? Y/N
- Have you ever had periodontal (gum) treatment? Y/N If Yes, Year: _____
- Have you ever had orthodontic (braces) treatment? Y/N If Yes, Year? _____
- Have you ever had any problem with dental treatment? Y/N
  If Yes, please explain:
  _____
- Are you currently experiencing any dental pain or discomfort? Y/N
  If Yes, please explain:
  _____
- Do you have clicking / popping / discomfort in your jaw? Y/N
- Do you, or has anyone ever told you that you, clench or grind your teeth? Y/N
- Do you wear a night guard at night when you sleep? Y/N
- Do you get sores or ulcers in your mouth? Y/N
  If Yes, how often? _____
- Do you wear partials or dentures? Y/N If Yes, Do you like the way they fit? Y/N
- Date of your last dental exam: _____
- Date of your last dental x-rays: _____
- Reason for your visit today:
  _____
- Is there anything about your smile you would like to change? Y/N
  If Yes, please explain:
  _____

PATIENT SIGNATURE: _____ **DATE:** _____

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FINANCIAL POLICY:

- Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service.
- Payments may be made using cash, check, Visa, MasterCard, Amex and/or Discover. We also offer CARECREDIT, which is a financing option that is available only for healthcare expenses. Ask for an application if you want to use this method.
- Insurance Information: As a courtesy to our insured patients, we submit claims to your insurance company. We will help you to receive your maximum allowable benefits. We will need a copy of your insurance card prior to your 1st appointment.

❖ **Dr. Harrison will diagnose treatment based on your dental health needs not your insurance coverage.**

- Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay, however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.
- If your insurance has not paid within 90 days of services rendered, you will need to make full payment our office and will be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided in order to assist you with your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

PATIENT SIGNATURE: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES:

This Notice describes how dental and medical information about you may be used and disclosed, and how much you can get access to this information.

Millennium Dental fulfills its legal duty to its patients by maintaining the privacy of protected health information at all times.

I acknowledge that I have been provided with a copy of the office "Notice of Privacy Practices"

PATIENT SIGNATURE: _____ **DATE:** _____

Please provide a list of parties other than those stated by law that you would like to disclose information regarding to your care:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____