

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Date _____

Soc. Sec. # _____

Birthdate _____

Patient's Name _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Pager _____

(Check Appropriate Box) Minor Single Married Divorced Widowed Separated

If Student Name of School/College _____ Full time Part time

Address _____
(Street) (City) (State) (Zip)

Patient's Employer: _____ Work Phone _____

Address _____
(Street) (City) (State) (Zip)

Spouse or Parent's Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Spouse or Parent's Employer _____ Work Phone _____

Person Responsible for this Account _____

Address _____ Phone _____

Relationship to Patient _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____

Person to contact in case of emergency or to change appointment of patient cannot be reached:

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION:

Name of Insured _____ Relationship to Patient _____

Primary Insurance Carrier Name _____

Policy # _____ Group # _____

Secondary Insurance Carrier Name _____

Policy # _____ Group # _____

Do you have a Co-Pay with your insurance plan for office visits? _____

If so, what is the amount? _____ Co-Pay's are to be paid at the time of service.

For your convenience, we offer the following methods of payment. Please check the option you prefer.

- Cash Personal Check Credit Card VISA MasterCard I wish to discuss other options.

AUTHORIZATION AND RELEASE:

I/We authorize the dentists and staff of Tower Dental in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. I/We acknowledge that no guarantees have been made as to the results of my treatments, tests or procedures, and I/We authorize copies of the medical records to be released to other physicians, dentists or health care facilities as deemed necessary.

ASSIGNMENT OF BENEFITS:

I/We assign all benefits to Tower Dental, and authorize direct payment to Tower Dental of all insurance benefits to which I/We or the patient may be entitled. This assignment specifically includes, but is not limited to, insurance proceeds and benefits as well as proceeds and benefits accruing under any settlement, structured or otherwise, or award in judgment for injuries and damages caused by a third party.

FINANCIAL RESPONSIBILITY:

I/We agree to pay for any and all charges not paid pursuant to this assignment, and a photocopy of this assignment shall be as valid as an original. I/We understand the I/We am/are financially responsible to Tower Dental as the patient, parent, guardian, conservator, insured or guarantor for all charges not covered by the above assignment, which charges may include any dental insurance deductibles or co-insurance. I/We understand to sign as a guarantor means that if the patient does not pay Tower Dental for all charges due, I/We, as the guarantor, will be responsible for such payment. I/We authorize Tower Dental and any dentist, staff member, or office administrator for Tower Dental to release any medical information about the patient necessary to determine any benefits which maybe payable for this treatment. I/We understand that I/We am/are responsible for all fees and costs regardless of the insurance coverage. I/We agree to pay a late payment fee at the rate of 1 1/3 percent per month on any amounts due from and after the thirty-first day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim for insurance is pending, no late payment fee shall accrue until such time as the insurance company denies all or part of a claim, in which case I/We agree to pay late payment fee at the rate of 1 1/3 percent per month on any unpaid amounts from and after the thirty-first day following the date Tower Dental or I/We receives notice of the same from the applicable insurance company, whichever is earlier. I/We also agree that if any dispute arises between Tower Dental, its representatives or employees and me, the laws of the State of Nebraska. shall govern, and all such disputes must only be litigated in the appropriate court in Douglas County, Nebraska, and I/We consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

The undersigned certifies that he or she is the patient or is duly authorized by or on behalf of the patient to execute the above and accept such terms and conditions.

Date: _____

Patient's signature

Date: _____

Parent, Guardian, Conservator, Insured,
Power of Attorney, Guarantor

PATIENT HISTORY

Physician _____ Office Phone _____ Last Date of Exam _____

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| <p>1. Are you under medical treatment now? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? If yes, please explain YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you taking any medication (s) including non-prescription medicine? If yes, what medication(s) are you taking? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Have you ever taken Phen-Fen/Redux? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you use tobacco? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Do you use controlled substances? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you ever been treated for substance abuse? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Are you wearing contact lenses? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Do you have or have you had any of the following?</p> | <p>10. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novocaine) YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or any other antibiotics YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa Drugs YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbituates YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Sedatives YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Any metals (e.g., nickel, mercury, etc.) YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex Rubber YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Other (please list) YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Women Only:</p> <p>a. Are you pregnant or think you may be pregnant? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Are you nursing? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Are you taking oral contraceptives? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> |
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| <p>High Blood Pressure Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Attack Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic Fever Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Swollen Ankles Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting/Seizures Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Low Blood Pressure Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy/Convulsions Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Leukemia Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney Disease Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV Infection Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Problem Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> | <p>Heart Disease Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Mitral Valve Prolapse Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Murmur Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Frequently Tired Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis/Rheumatism Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement or Implant Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis/Jaundice Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually Transmitted Disease Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Stomach Troubles/Ulcers Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> | <p>Chest pains Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Easily Winded Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay Fever/Allergies Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Radiation Therapy Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Glaucoma Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Recent Weight Loss Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Liver Disease Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Psychiatric Treatment Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Respiratory Problems Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Bleeding Disorder Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> |
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PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Last Date of Exam _____
 Previous Dentist's Location _____ Date of Last Cleaning _____

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| <p>1. Do your gums bleed while brushing or flossing? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Do you feel pain to any of your teeth?
 Do you have any sores or lumps in or near your mouth?
 Have you had any head, neck or jaw injuries? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you ever experienced any of the following problems in your jaw?
 Clicking YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Pain (Joint, ear, side of face) YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty in opening or closing YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty in chewing YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever "whitened" your teeth? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> | <p>8. Do you have frequent headaches? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Do you clench or grind your teeth? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Do you bite your lips or cheeks frequently? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Have you ever had difficult extractions in the past? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Have you ever had any prolonged bleeding following extractions? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Have you had any orthodontic treatment? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Do you wear dentures or partials? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Do you like your smile? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> |
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If you could change one thing about your teeth or smile, what would it be?

 (Signature of Patient or Parent if Minor) Date: _____

Doctor's Notes _____

Signature: _____ Date: _____