soldental

# Patient Registration Form

Date of Appointment: _____

## Patient Information

| Patient's First Name | Middle Name | Last Name (as it appears on insurance card or ID) |
|---|---|---|
| | | |

| Sex | Maritial Status | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |

| Patient's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Mobile Phone | Email Address |
|---|---|---|
| | | |

| How did you hear about us? | Preferred day/time for appointments | ☐ Permission to text | ☐ Permission to e-mail |
|---|---|---|---|
| | | | |

## Patient Employer Information

| Employer | Occupation | Employer Phone |
|---|---|---|
| | | |

| Employer Address | City | State | Zip |
|---|---|---|---|
| | | | |

## Emergency Contact Information

| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|---|---|---|
| | | |

## Billing and Insurance

### Primary Dental Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Member/Subscriber ID Number | Group Number | Insured's Employer/School |
|---|---|---|
| | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

| Insured's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Insured's Social Security Number | Insured's Date of Birth |
|---|---|
| | |

### Secondary Dental Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School | Insured's Social Security Number |
|---|---|---|---|
| | | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

### Responsible Party

| Billing Name (if other than patient) | Phone | Relation to Patient |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

## ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

**Sol Dental, PLLC**, all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submissions.

I grant the right to Sol Dental, PPLC and Jaclyn R. Haendel, D.D.S. to release health information obtained from me, and information about my dental treatment to third party payers and/or health practitioners.

**Signature of Patient or Authorized Guardian** | **Please print name of Patient or Authorized Guardian** | **Realationship to Patient** | **Date**

Name _____ Gender _____ Age _____

Date of Appointment: _____

## Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

## Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

☐ More included on back of form
☐ Copy given to office staff

| Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Asprin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

| Name | Reaction |
|---|---|
| | |
| | |

## Hospitalizations & Surgeries

| Reason | Date |
|---|---|
| | |
| | |
| | |

Have you ever had to premedicate before a dental appointment? ☐ Yes ☐ No

Reason _____

## Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush? # times / day _____

How often do you floss? # times / day _____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Are you happy with the appearance of your smile? ☐ Yes ☐ No _____

## Medical History

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

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Attack
☐ Arthritis ☐ Cancer ☐ Heart Disease
☐ Asthma ☐ Diabetes ☐ Heart Problems
☐ AIDS / HIV ☐ Depression ☐ Heart Valve Replacement
☐ Hepatitis - A, B, or C ☐ Lung Disease ☐ Sinus Problems
☐ High Blood Pressure ☐ Lupus ☐ Skin Disorder
☐ High Cholesterol ☐ Measles ☐ Stroke
☐ Hip/Knee Replacement ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Venereal Disease

## Lifestyle Factors

Have you ever smoked or used tobacco? ☐ Yes ☐ No # packs/day _____

# of years _____ Quit Date _____

Do you use smoke or use tobacco now? ☐ Yes ☐ No # packs/day _____

Do you use recreational drugs? ☐ Yes ☐ No

types? _____ # times/week _____

How much alcohol do you drink per week? # drinks/week _____

## Women Only

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

What is your method of birth control?

_____

I certify that I have answered the above quesions honestly and accuractely, to the best of my knowledge.
I understand that should there be a change in my health, I am to inform the dentist at the earliest possible time.

**Signature of Patient or Authorized Guardian** | **Please print name of Patient or Authorized Guardian** | **Realationship to Patient** | **Date**

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# FINANCIAL POLICY

Payment for services received is due at the same time services are rendered. We accept debit/credit cards, personal checks, Care Credit and cash for your convenience.

**REGARDING APPOINTMENTS**:
Your appointment time is reserved specifically for you. If you are unable to keep your appointment, we ask that as a courtesy, you give us 48-hour notice. We have an answering machine if you need to call after hours and leave a message or you may email us at info@soldentalaz.com. In order to prevent unnecessary delays in your treatment, we ask that you reschedule your appointment as soon as possible.

Failure to give **24-hour** notice will result in a broken appointment fee of $25.

**REGARDING INSURANCE**:
As an added benefit to our patients, we are in-network with several insurance companies and will bill them on assignment, but we must collect all estimated co-pays and deductibles at the time of service. You will only be billed additionally if your insurance does not pay their estimated amount. Verification of benefits is required before we start treatment. If we are unable to verify your benefits, regardless of your insurance status, you will be responsible for payment in full at the time services are rendered. It is your responsibility to notify our office if your benefits have changed

Our office cannot guarantee that your insurance will pay their estimated portion. If your insurance company fails to pay your claim within 60 days, you will be billed directly for any applicable amounts.

**REGARDING ESTIMATES:**
As a courtesy at Sol Dental, we try to estimate what your portion of the charges will be and what percentage of a procedure, if any, is a covered benefit by your plan. We can usually estimate with a reasonable degree of accuracy, however there are literally hundreds of dental insurance plans, each with different maximums, percentages, covered procedures, etc. In addition, each claim is reviewed by the insurance company on an individual basis so even though the service may be listed as a covered benefit by your plan, it does not guarantee the insurance company will pay for your service.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Your insurance benefit is a contract between you and your insurance company and we are legally required to honor that contract and collect payment for all applicable co-pays, deductibles and uncovered services as dictated by the insurance company. We are, however, happy to provide whatever supporting documents and narratives that may be needed to assist you in obtaining your rightful benefits.

*All accounts turned over to our collections agency will be subject to added financial charges, collection costs, attorney's fees, and any other costs that may be incurred to enforce the collections of any amount outstanding.*

***I have read and understand the above statements.***

_____

***Signature (Parent or Guardian, if minor)*** ***Date***

*If you have any questions concerning our financial policy, please ask one of our team members to assist you.*