Glenbrook FAMILY DENTISTRY

Patient Registration Form

Glenbrook Family Dentistry
435 West Coliseum Blvd.
Fort Wayne, IN 46805

Name	Sex: M F	Birth date:	Today's Date:
Home Address	City	State	Zip
Previous Address	City	State	Zip
Please Circle one: Single married separated widowed	Occupation	Home Phone:	
Your Employer	How Long? SS#		Work Phone:
Are you a full time student? ❒Yes ❒No	If patient is minor: Mother's Birth date:		Father's Birth date:
Name of Spouse (Parent if Minor):	Email:		Cell Phone:
Spouse's (Parent's) Employer:	Spouse(Parent's) SS#:		Work Phone
Referred to us by:	Name, Address, & Telephone of		
Reason for visit:	Relative not living with you		

Dental Insurance Information (Primary Carrier)			Complete this for Secondary Coverage		
Insured's Name	DOB:	SS#	Insured's Name	DOB:	SS#
Insured's Employer			Insured's Employer		
Insurance Co.			Insurance Co.		
Insurance Co Address			Insurance Co Address		
Phone No			Phone No		
Group #	Local #		Group #	Local #	

It is important that we know about your Medical and Dental History. These facts have direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Medical History	Yes	No	If yes, Explain
Do you have any current health problems?	❒	❒	
Are you under a Physician's care now?	❒	❒	
Are you currently taking any medications	❒	❒	

PLEASE CHECK YES OR NO

	Yes	No		Yes	No		Yes	No
Aids	❒	❒	Excessive Bleeding	❒	❒	Pacemaker	❒	❒
Anemia	❒	❒	Fainting	❒	❒	Phen Fen(if taken > 1 month)	❒	❒
Allergies	❒	❒	Glaucoma	❒	❒	Pregnant-currently	❒	❒
Angina Pectoris	❒	❒	Hay Fever	❒	❒	Psychiatric Treatment	❒	❒
Arthritis	❒	❒	Heart Disease/Attack	❒	❒	Radiation Treatment	❒	❒
Artificial Heart Valve	❒	❒	Heart Murmur	❒	❒	Respiratory Problem	❒	❒
Artificial Joints	❒	❒	Heart Surgery	❒	❒	Rheumatism	❒	❒
Asthma	❒	❒	Hepatitis A	❒	❒	Scarlet Fever	❒	❒
Blood Disease	❒	❒	Hepatitis B	❒	❒	Sinus Problems	❒	❒
Bruise Easily	❒	❒	High Blood Pressure	❒	❒	Stomach Problems	❒	❒
Cancer	❒	❒	HIV Positive	❒	❒	Stroke	❒	❒
Chemotherapy	❒	❒	Jaundice	❒	❒	Thyroid Disease	❒	❒
Congenital Heart Lesions	❒	❒	Jaw Joint Pain	❒	❒	Tuberculosis	❒	❒
Dizziness	❒	❒	Kidney Disease	❒	❒	Ulcers	❒	❒
Diabetes	❒	❒	Liver Disease	❒	❒	Venereal Disease	❒	❒
Drug Addiction	❒	❒	Low Blood Pressure	❒	❒	Other__________________	❒	❒
Emphysema	❒	❒	Mitral Valve Prolapse	❒	❒		❒	❒
Epilepsy	❒	❒	Nervous Disorder	❒	❒	If Pregnant-Due Date ________		

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No
Aspirin	❒	❒	Percodan	❒	❒	Erythromycin	❒	❒
Darvon	❒	❒	Local Anesthetic	❒	❒	Valium	❒	❒
Nitrous Oxide	❒	❒	Codeine	❒	❒	Penicillin	❒	❒
						Other ________________________		

Family Physician________________________Phone Number______________________

Is there any other medical or dental information that you feel I should know about?

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CONSENT FOR TREATMENT: The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. The above information provided is an accurate representation of my health and all prescription medicines are listed. I understand that dental treatment in and of it self embodies a certain risk and that additional treatment other than what initially prescribed may be required to help save my teeth.

PATIENT Signature (Parent of Child) ______________________ Date: ________________ DENTIST Signature ________________

Financial Policy

Thank you for choosing the office of Glenbrook Family Dentistry for your dental health needs. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health throughout your life. Please understand that your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval. Please ask if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred. The minimum charge for a collection service and/or legal assistance is 35% of uncollected charges.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, or with the patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless if any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- At the time of service we ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover.
- Insurance payments are ordinarily received within 30-60 days from time of filing. If your insurance company has not been made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- If you do not wish to have our assistance with your insurance claims, you may choose to pay at the time of service and submit the insurance claim yourself. Talk to our office manager if this is your desire.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning your care or our financial policy.

CONSENT:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, re-billing, collection charge or attorney fee will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child)______________________________ Date____________________