Dental Registration Form
Dental Group of Mentor

Name (First, MI, Last) _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

May we call you during the day? YES / NO Where? _____ Date of birth _____

Occupation _____ Social security # _____ Driver's License # _____

Marital Status Single / Married / Widowed / Divorced

Employed by _____ City and Phone # _____

Person responsible for account _____

Person to nogify in an emergency _____ Phone # _____

Email address _____

Please answer:

May we give information regarding your treatment or discuss billing issues with anyone other than yourself YES/NO

If so, who: _____

May we leave a message on voicemail or an answering machine regarding treatment / billing? YES/NO

How did you come to know of our office? ☐ Yellow Pages ☐ Good Location ☐ Insurance Co.

☐ Referred by one of our patients. His or her name: _____ ☐ Other: Please specify _____

I hearby authorize the doctor to perform any forms of treatment, medication, and therapy, which may be deemed necessary.
I also understand that before treatment, the doctor and/or staff will give full explanation of the procedure(s) involved.
I agree to pay for services rendered by this dental practice.

Signed (patient or parent if minor) _____ Date: _____

I authorize the use of any radiographs and/or photographs for use in seminars or publications of Dental Group of Mentor.

Signed (patient or parent if minor) _____ Date: _____

Dental Insurance Information

Insured is: ☐ self ☐ husband ☐ wife ☐ mother ☐ father

Employee's name _____ Employee's SS# _____ Employee's date of birth _____

Employer _____ Employer telepone # _____

Group number _____ Insurance co. _____

Does a second insurance company cover you? YES / NO

Second Insurance Carrier Information

Employee's name _____ Employee's SS# for 2nd Ins. _____ Employee's date of birth _____

Employer _____ Employer telepone # _____

Group number _____ Insurance co. _____

I understand that as a service to me, Dental Group of Mentor will assist me in processing my insurance claims.
However, I understand that I am completely responsible for all fees.

Signed (patient or parent if minor) _____ Date: _____

Dental Group of Mentor

MEDICAL HISTORY

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

Are you under a physican'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 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
Do you use tobacco? YES / NO
Do you use controlled substances? YES / NO

Woman: Are you:
Pregnant / Trying to get pregnant? YES / NO Taking oral contraceptives? YES / NO Nursing? YES / NO

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anesthetics ☐ Other - If yes, please explain:

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

AIDS/HIV Positive YES / NO	Cortisone Medicine YES / NO	Hemophilia YES / NO	Renal Dialysis YES / NO
Alzheimer's Disease YES / NO	Diabetes YES / NO	Hepatitis A YES / NO	Rheumatic Fever YES / NO
Anaphylaxis YES / NO	Drug Addiction YES / NO	Hepatitis B or C YES / NO	Rheumatism YES / NO
Anemia YES / NO	Easily Winded YES / NO	Herpes YES / NO	Scarlet Fever YES / NO
Angina YES / NO	Emphysema YES / NO	High Blood Pressure YES / NO	Shingles YES / NO
Arthritis/Gout YES / NO	Epilepsy or Seizures YES / NO	Hives or Rash YES / NO	Sickle Cell Disease YES / NO
Artificial Heart Valve YES / NO	Excessive Bleeding YES / NO	Hypoglycemia YES / NO	Sinus Trouble YES / NO
Artificial Joint YES / NO	Excessive Thirst YES / NO	Irregular Heartbeat YES / NO	Spina Bifida YES / NO
Asthma YES / NO	Faiting Spells/Dizziness YES / NO	Kidney Problems YES / NO	Stomach/Intestinal Diseases YES / NO
Blood Disease YES / NO	Frequent Cough YES / NO	Leukemia YES / NO	Stroke YES / NO
Blood Transfusion YES / NO	Frequent Diarrhea YES / NO	Liver Disease YES / NO	Swelling of Limbs YES / NO
Breathing Problem YES / NO	Frequent Headaches YES / NO	Low Blood Pressure YES / NO	Thyroid Disease YES / NO
Bruise Easily YES / NO	Genital Herpes YES / NO	Lung Disease YES / NO	Tonsillitis YES / NO
Cancer YES / NO	Glaucoma YES / NO	Mitral Valve Prolapse YES / NO	Tuberculosis YES / NO
Chemotherapy YES / NO	Hay Fever YES / NO	Pain in Jaw Joints YES / NO	Tumors or Growths YES / NO
Chest Pains YES / NO	Heart Attack/Failure YES / NO	Parathyroid Disease YES / NO	Ulcers YES / NO
Cold Sores/Fever Blisters YES / NO	Heart Murmur YES / NO	Psychiatric Care YES / NO	Venereal Disease YES / NO
Congenital Heart Disease YES / NO	Heart Pace Maker YES / NO	Radiation Treatments YES / NO	Yellow Jaundice YES / NO
Convulsion YES / NO	Heart Trouble/Disease YES / NO	Recent Weight Loss YES / NO	

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect infomration 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, Parent or Guardian _____ Date _____

Dental Group of Mentor

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to disclose my protected health information to carry out:

> Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
> Obtaining payment from third party payers (e.g. my insurance company);
> The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privay Practices,* which contains a more completed description of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this otice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatent, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are bound to comply with these instructions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name _____

Signature of Patient / Guardian _____

Relationship to Patient _____

Dental Group of Mentor
9571 Mentor Avenue, Mentor, OH 44060
(440) 352-5700

Dental Group of Mentor
Financial Policy

Dear Patient:

In an effort to reduce costs, increase efficiency and maintain the highest level of professional care, we have established a financial policy that both patients and office personnel must adhere to.

Our Office Financial Policy is as follows:

I. We accept payment by CASH, CHECK, and MOST MAJOR CREDIT CARDS.

II. As a courtesy, we will accept most insurances. and will gladly process your claim - however any estimated deductibles, co-payments, and secondary coverages will be due in full at time of visit.

_____ **Initialed by patient.**

III. Although our office will process your insurance claims, please understand it is your responsibility to satisfy any account blanace in full for all services rendered.

If you hae any questions regarding these financial policies, please do not hesistate to speak to our office personnel. We are here to help you in every way.

PLEASE ACKNOWLEDGE THAT YOU UNDERSTAND THE ABOVE POLICIES

Patient Signature:_____ Date: _____

_____

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