TRUMBULL PREMIER
DENTAL

New Patient Registration Form

Date: _____

Mr. Mrs. Ms. Miss Dr.

First Name _____ MI_____ Last Name_____

Preferred Name: _____ Birth Date: _____/_____/_____

Spouse's Name: _____

Social Security #: _____-_____-_____ Driver's License # _____ State _____

Address_____City_____State_____Zip _____

Cell Phone #: _____ Home: _____ Work: _____

E-Mail: _____

What is the best way to contact you and hear back from you quickly: _____ Best time to call: _____

How did you hear about our office? _____

Employment Information:

The following is for the patient:

Employer Name: _____ Occupation: _____

Address: _____City_____State_____Zip Code_____

Dental History:

Your current dental Health is: _____Excellent _____Good _____Fair _____Poor _____Hopeless

Date of last dental visit? _____

When was your last dental cleaning? _____

Are you currently in Pain? _____No _____Yes

_____

_____

Health Information

Although dental visits 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 honestly.

Patient Name: _____Today's Date_____

Have you ever had any of the following? Please check all that apply:

☐Anemia
☐Angina
☐Arthritis
☐Artificial Joints
☐Artificial Heart Valve
☐Leaky Heart Valve
☐Asthma
☐Blood Disease
☐Blood Thinner
☐Blood Transfusion
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Cold Sores/Fever Blisters
☐Convulsions
☐Cortisone Medication
☐Diabetes
☐Diet: (Special/ Restricted)
☐Dizziness
☐Drug/Alcohol Addiction
☐ Dry Mouth
☐Emphysema
☐Epilepsy
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting
☐Frequent Cough
☐Gerd
☐Glaucoma
☐Hay Fever
☐Headaches
☐H. I. V. Positive
☐Head Injuries
☐Heart (Attack, Disease, Surgery)
☐Heart Murmur
☐Hemophilia
☐Hepatitis – A B C
☐High Blood Pressure
☐Hives or rash
☐Hypoglycemia
☐Kidney Disease
☐Latex Sensitivity
☐Leukemia
☐Liver Disease
☐Mental Disorders
☐Emotional Disorders
☐Mitral Valve Prolapse
☐Nervous Disorders
☐Pacemaker
☐Psychiatric
_____
☐Are you Pregnant?
_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Smoke/Chew Tobacco
☐Stomach Problems
☐Stress
☐Stroke
☐Thyroid Problems
☐Tuberculosis
☐Tumors
☐Ulcers
☐Codeine Allergy
☐Penicillin Allergy
☐**Have you ever been told to take an antibiotic before dental visits? ____ Yes ____ No**

Height: _____

Weight: _____

Are you Allergic to any of the following (please circle):

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa

Other allergies? If yes, please explain: _____

Are you taking an Aspirin a day? _____Are you taking Blood Thinners? _____

Have you been admitted to a hospital or needed emergency care during the past two years? _____No
_____Yes_____

Do you see a physician regularly (annual physical/exams)? _____Yes _____No

Name of Physician: _____ Phone: _____

Do you have any health problems that need clarification? _____No
_____Yes_____

Are you taking any medications? Please list_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_

_____

Signature of patient, parent or guardian Date

Please Handle Me with Care

Put a checkmark on the line next to the statement(s) that concern or describe you. Please bring this form along with you to your dental appointment.

_____ I gag easily.

_____ I feel out of control while I'm lying down in the dental chair.

_____ I have not been to a dentist for a long time and I am worried about what you will tell me about my teeth and my dental hygiene.

_____ I am embarrassed about the way my teeth look.

_____ I have had a bad dental experience and have a lot of fear that has kept me from getting the dental care I need.

_____ I am very apprehensive about the possibility of experiencing any pain. Therefore, pain relief is a top priority for me.

_____ Please tell me what I need to know about my mouth so that I can make informed decisions.

_____ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me.

_____ I have difficulty listening and remembering when I am in the dental chair.

_____ I would like to see pictures and videos that will help me understand my dental problems and their solutions.

_____ Please respect my time. I don't want to be left sitting in the reception area.

Other_____

_____

_____

_____

_____

Dental Health

What is your biggest dental problem? _____

_____

_____

What do you see happening with your teeth over the next 10 years? _____

_____

_____

Ideally, what condition do you want your mouth to be in? And what would that look and feel like:

_____

_____

When would you like to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or dental emergencies?
_____No
_____Yes_____
_____

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? _____Yes _____No

Do you or anyone you know snore? _____

How many times do you: floss/week? _____ Brush/week? _____

Do you avoid brushing any areas of your mouth because of tenderness? _____Yes _____No

Do you like your smile? _____Yes _____No

Would you like your teeth to be whiter? _____Yes _____No

Rate your smile from 1-10 (1 = hate it and 10 = Love it) _____

Is there anything you would like to change about your smile? _____Yes _____No
_____

_____

_____

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Consent for Services and Financial Information

1. I hereby authorize Dr. Cuevas and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Cuevas to make a thorough diagnosis of my/my dependents' dental needs. Upon such diagnosis, I authorize Dr. Cuevas to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
2. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.
3. Payment for services is due the day the services are provided. We have several payment options available to you, which we will be happy to discuss with you at your request. You understand that if payment is not made within thirty (30) days of the billing date that interest will accrue at a rate of 1.5% per month (18% annual rate) and you will be responsible for all interest charges.
4. As a courtesy, we will file your dental insurance on your behalf. However, you agree that knowing your insurance coverage is your responsibility. We are not responsible for incorrect information provided by your insurance carrier.
5. You agree that it is your responsibility to inform our office of any insurance and/or personal contact information. We are not responsible for insurance claims that are denied for timely filing because we did not receive your insurance information on a timely basis.
6. We cannot be responsible for interpreting your insurance policy terms and conditions, and we do not in any way guarantee insurance payment for any services.
7. We are not responsible for following up with your insurance company once we have filed the claim on your behalf. Any insurance payments not received within forty five (45) days are your responsibility. You also agree that you are responsibility for all amounts not paid by your insurance.
8. You agree that you or any person responsible for paying your bill must give 24-hour notice of appointment cancellation. If you fail to give proper notice, you hereby give consent to be billed for that time at the rate of 150.00 per hour.
9. If you or any person paying your bill issues a check to us that is returned for insufficient funds, you agree to be responsible for a returned check charge of twenty-five dollars ($ 25.00). You also understand that if you do not make replacement payment in full of the NSF check within ten (10) days, that we will pursue all civil and criminal remedies available to us to collect the full amount of the NSF check, and that you will be responsible for all costs of collection.
10. It is also agreed that upon your failure to pay any invoice when due, we may place your account with an attorney or a collection agency for collection. You hereby agree to pay all costs of collection, including but not limited to commission for collection agency, interest at 18% per annum, reasonable attorney's fees and court costs.
11. If your account is referred to a collection agency or an attorney due to non-payment, you hereby acknowledge and agree that such collection agency or attorney may obtain credit information about you from any source, including, without limitation, consumer credit reporting agencies, employers, and banks. Additionally, in the case of default, you also understand that your information may be reported to credit reporting agencies.
12. If your account is referred to a collection agency or an attorney due to non-payment, you hereby agree that you have been advised and give permission to be contacted using any and all of the contact information provided in this registration form.

Signature_____Date_____

Printed Name_____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that a copy of this office's Notice of Privacy Practices is available for me to have at any time at my request.

Signature_____Date_____

Print Name_____

Release of Information

May we send appointment reminders via email or cell phone? _____Yes _____No

May we leave detailed information on your home answering machine? _____Yes _____No

May we leave detailed clinical information on your cell phone? _____Yes _____No

I authorize the release of information including the examination, diagnosis, and records rendered to me and/or claims/account information to my family member(s) and/or Doctor(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information is not to be released to anyone _____

Insurance Information

Please present your insurance card(s) to for copying.

Do you have Dental Insurance? _____Yes _____No

Name of Dental Insurance policy holder: _____

Date of birth of Dental Insurance policy holder: _____/_____/_____

Social Security of policy holder: _____/_____/_____

Patient's relationship to insured: ____ Self ____ Spouse ____Parent ____ Other (specify) _____

Dental insurance company name: _____

Do you have Medical Insurance? _____Yes _____No

Name of Medical Insurance policy holder: _____

Date of birth of Medical Insurance policy holder: _____/_____/_____

Social Security of policy holder: _____/_____/_____

Patient's relationship to insured: ____ Self ____ Spouse ____Parent ____ Other (specify) _____

Medical Insurance company name: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Print Name_____Date_____