Fresh Family DENTAL

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972-546-3888

Patient Registration:

First Name: _____ Last Name:_____ Middle Name:_____
Address: _____ City: _____ State: _____ Zip Code:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birthday: _____ Social Security #: _____ Email: _____
Sex: ◯ Male ◯ Female **Marital Status:** ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed
Employer: _____ Occupation: _____
Referred by: ☐ Family Friend (who)_____ Google ☐ Facebook ☐ Yelp ☐ Flyer ☐ Website ☐
Previous Dentist: _____
Emergency Contact: _____ Phone Number: _____
Preferred Pharmacy: _____

Responsible Party: Patient is: ☐ Responsible party

First Name: _____ Last Name: _____ Middle Initial: _____
Relation to patient: _____
Address: _____ City: _____ State: _____ Zip Code:_____
Home Phone: _____ Cell Phone: _____ Work Phone:_____
Birthday: _____ Social Security #: _____ Email: _____
Employer: _____ Occupation: _____

Primary Insurance Information:

Dental Insurance Company: _____
ID Number/ member ID: _____
Policy Holder Name: _____
Policy Holder Birthday: _____
Policy Holder SSN: _____
Policy Holder Address: _____
Policy Holder Zip Code: _____

Secondary Insurance Information:

Dental Insurance Company: _____
ID number/ Member ID: _____
Policy Holder Name: _____
Policy Holder Birthday : _____
Policy Holder SSN: _____
Policy Holder Address: _____
Policy Holder Zip Code: _____

Notice of Privacy Practices Patient Acknowledgement:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: _____ Date: _____
Relationship to patient: _____

I give my consent to Fresh Family Dental to notify/ contact me via email or text message which may include personal health information.(Ex: appointment reminder, notifications)

Signature: _____ Date: _____

Relationship to patient: _____

Medical History:

Patient Name: _____ Birthday: _____

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 have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

***If you answer yes to the following questions, please explain on the blank provided.**

	Y / N
Are you under a physician's care now?	☐ ☐
Have you ever been hospitalized or had a major operation?	☐ ☐
Have you ever had a serious head or neck injury?	☐ ☐
Are you taking any medications, pills or drugs?	☐ ☐
If yes, please provide a MED list:	
Do you take, or have you taken Phen-Fen or Redux?	☐ ☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing Bisphosphonates?	☐ ☐
Are you on a special diet?	☐ ☐
Do you use tobacco?	☐ ☐
Do you use controlled substance?	☐ ☐

*Woman, are you: (Circle all that apply) ☐ Pregnant ☐ Trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

Are you allergic to any of the following?

*Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐

*Latex ☐ Sulfa Drugs ☐ Others ☐ If yes please explain: _____

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

	Y / N		Y / N		Y / N		Y / N
AIDS/HIV Positive	☐ ☐	Cortisone Medicine	☐ ☐	Hemophilia	☐ ☐	Recent Weight Loss	☐ ☐
Alzheimer's Disease	☐ ☐	Diabetes	☐ ☐	Hepatitis A	☐ ☐	Renal Dialysis	☐ ☐
Anaphylaxis	☐ ☐	Drug Addiction	☐ ☐	Hepatitis B or C	☐ ☐	Rheumatic Fever	☐ ☐
Anemia	☐ ☐	Easily Winded	☐ ☐	Herpes	☐ ☐	Rheumatism	☐ ☐
Angina	☐ ☐	Emphysema	☐ ☐	High Blood Pressure	☐ ☐	Scarlet Fever	☐ ☐
Arthritis / Gout	☐ ☐	Epilepsy or Seizures	☐ ☐	High Cholesterol	☐ ☐	Shingles	☐ ☐
Artificial Heart Valve	☐ ☐	Excessive Bleeding	☐ ☐	Hives or Rash	☐ ☐	Sickle Cell Disease	☐ ☐
Artificial Joint	☐ ☐	Excessive Thirst	☐ ☐	Hypoglycemia	☐ ☐	Sinus Trouble	☐ ☐
Asthma	☐ ☐	Fainting spells/ Dizziness	☐ ☐	Irregular Heartbeat	☐ ☐	Spina Bifida	☐ ☐
Blood Disease	☐ ☐	Frequent Cough	☐ ☐	Kidney Problems	☐ ☐	Stomach/ Intestinal Disease	☐ ☐
Blood Transfusion	☐ ☐	Frequent Diarrhea	☐ ☐	Leukemia	☐ ☐		
Breathing Problem	☐ ☐	Frequent Headache	☐ ☐	Liver Disease	☐ ☐	Stroke	☐ ☐
Bruise Easily	☐ ☐	Genital Herpes	☐ ☐	Low Blood Pressure	☐ ☐	Swelling of Limbs	☐ ☐
Cancer	☐ ☐	Glaucoma	☐ ☐	Lung Disease	☐ ☐	Thyroid Disease	☐ ☐
Chemotherapy	☐ ☐	Hay Fever	☐ ☐	Mitral Valve Prolapse	☐ ☐	Tonsillitis	☐ ☐
Chest Pain	☐ ☐	Heart Attack / Failure	☐ ☐	Osteoporosis	☐ ☐	Tuberculosis	☐ ☐
Cold Sore/Fever Blister	☐ ☐	Heart Murmur	☐ ☐	Pain in Jaw Joints	☐ ☐	Tumors of Growth	☐ ☐
Congenital Heart Disorder	☐ ☐	Heart Pacemaker	☐ ☐	Parathyroid Disease	☐ ☐	Ulcers	☐ ☐
Convulsions	☐ ☐	Heart Trouble / Disease	☐ ☐	Psychiatric Care	☐ ☐	Venereal Disease	☐ ☐
				Radiation Treatment	☐ ☐	Yellow Jaundice	☐ ☐

Have you ever had an serious illness not listed above? _____

Comments:

To the best of my knowledge, the questions on this from have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. Its my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Doctors Signature: _____ Date: _____

Dental History

Name: _____ Date: _____

How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor?

Previous Dentist: _____ How long have you been a patient: _____

Date of most recent dental exam: _____ Date of most recent r-rays: _____

Date of most recent treatment (other than cleaning):_____

I routinely seen the dentist every: ☐ 3 Mon ☐ 4 Mon ☐ 6 Mon ☐ 12 Mon ☐ Not Routinely

What is your immediate concern? _____

Please answer YES or NO to the following questions: ***Y or N***

Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10(most) _____ ☐ ☐

Have you had an unfavorable dental experience? _____ ☐ ☐

Have you had complications from past dental treatment? _____ ☐ ☐

Have you ever had trouble getting numb or had ANY reaction to local anesthetic? _____ ☐ ☐

Did you ever have braces, orthodontics treatment or have your bite adjusted? _____ ☐ ☐

Have you had any teeth removed? _____ ☐ ☐

Smile Characteristic

Is there anything about the appearance of your teeth you would like to change? _____ ☐ ☐

Have you ever whitened (bleached) your teeth? _____ ☐ ☐

Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ ☐ ☐

Have you been disappointed with the appearance of pervious dental work? _____ ☐ ☐

Bite & Jaw Joint

Do you have problems with your jaw joints? (pain, sounds, limited opening, lock popping) _____ ☐ ☐

Do you/ would you have any problems chewing gum? _____ ☐ ☐

Do you/ would you have any problems chewing bagels, baguettes, protein bars, or any other hard foods? _____ ☐ ☐

Have your teeth changed in the last 5 years, becoming shorter, thinner or worn? _____ ☐ ☐

Are your teeth crowding or developing spaces? _____ ☐ ☐

Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐

Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? _____ ☐ ☐

Do you clench your teeth in the daytime, or do they become sore? _____ ☐ ☐

Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐

Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

Tooth Structure

Have you had any cavities within the past 3 years? _____ ☐ ☐

Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food? ____ ☐ ☐

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐

Are your teeth sensitive to hot, cold, biting, sweet, or do you avoid brushing any part of your mouth? _____ ☐ ☐

Do you have any grooves or notches on your teeth near the gum line? _____ ☐ ☐

Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling? _____ ☐ ☐

Do you frequently get food caught between any teeth? _____ ☐ ☐

Biology

Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐

Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐

Have you ever noticed an unpleasant odor in your mouth? _____ ☐ ☐

Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐

Have your ever-noticed gum recession? _____ ☐ ☐

Have you ever had any teeth become loose on their own (no injury, or do you have difficulty eating an apple?___ ☐ ☐

Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Signature of Patient, Parent, or Guardian: _____ Date: _____

Doctors Signature: _____Date: _____

Financial Policy

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative cost.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Insurance

As a courtesy to you, we will help you process all your insurance claims. In order for our practice to file your insurance claim, you must provide proof of insurance either with your card or information provided to the office when setting up the appointment. **All charges you incur are your responsibility regardless of your insurance coverage.**

Payment Due at Time of Service

Our policy is: **"Payment Due at Time of Service"**. Your estimate co-payment for treatment, which is the amount not covered by insurance , is due at the time treatment is provided. Your estimated co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If you do not have insurance, we expect full payment for service at each office visit.

We accept these forms of payment

*Cash *Check *Visa * Third Party Finance * Master Card * American Express

For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. Majority of dental insurances cover 50% or less on many services and cover nothing in others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible your coverage but until we receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a predetermination to their insurance carries. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately and some treatments should be started immediately. In these cases, we will ask you to pay for your service in full as they are done. When the insurance company pays their portion, we will reimburse you for what they paid. We will assist you in dealing with the insurance company but ultimately the responsibility of payment and insurance problems lies with you. If we do accept assignment od benefits from the insurance company, if the insurance company hasn't paid after 45 days the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot he treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding put financial policy. If you have any questions or concerns, please feel free to ask them at any time. We wish to be of assistance in any way we can.

Interest

Returned checks and balances older than 90 days will be subject to collection fees and charges at the rate of 1.5% per month (18% annually).

Please don't hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care but need your financial commitment as well.

Print Name of Patient or responsible party: _____

Signature of patient or responsible party: _____Date: _____

Appointment Policy

I understand the cancellation policy which states " Reserved times cancelled within 48 hours are subject to a $50.00 cancellation fee". An appointment cancelled within 48 hours limits our ability to fill the time with a patient in need, we appreciate your understanding and working with us to avid this scenario.

Signature of patient or responsible party: _____ Date: _____

Informed Consent for Initial Examination, X-Rays & Cleaning

Patients name: _____

1. Dental Office Informed Consent- Its important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may with your agreement perform. We want to involve you in all decisions concerning incisive procedure you may need. We take informed consent very seriously in our office. Therefore, we only want you to initial form when you understand that there is a risk associated with dental procedures, and all your questions have been answered. Dental treatment and procedures are not to be take for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment. There are no guarantees that the results will be as planned and to everyone's satisfactions. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like 'fillings" can lead to major complications that cannot be foreseen. For example, "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatment. The above examples are only samples of possible complications with dental treatment and are not limits to these. In general , complications include but are not limited to pain, swelling, bleeding, infections, other nerve problems. I have read & understood and give my consent to dental treatment. **(Initials_____)**

2. **Examinations and x-rays-** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that I have to get treatment done as detailed in the treatment plan based on diagnosis by Dr. Patel **(Initials_____)**

3. Dental Photography- I authorize to take photography's, and/or videos of my face, jaws and teeth, before during and after treatment. I consent to allow the photographs to be used for the follow:

*Dental Records * Dental Research* Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books *Marketing material, including websites, printed materials, patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of my photographs**. (Initials _____)**

4. **Drugs/ Medications**- I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and / or anaphylactic shock (server allergic reaction.) they may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that maybe have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risk of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompany risk, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking. I have informed Dr. Patel of any known drug allergies **(Initials_____)**

5. **Changes in treatment Plan**- I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Patel to make changes and additions as necessary. **(Initials_____)**

6. **Tempro- Mandibular Joint Dysfunction (TMJD)** - I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMDJ associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. **(Initials_____)**

7. **Dental Prophylaxis (Cleaning)**- I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums and is limited to the removal of plaque and extremely light tarter & stains from tooth structures in the absence of periodontal (gum) disease. This treatment prevents gingivitis & gum disease**. (Initials _____)**

Signature of patient, parent, guardian: _____Date: _____

Doctors Signature: _____ Date: _____