PATIENT REGISTRATION

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.

Date
Patient Name
Address
City State Zip
Best way to contact you: H W C Phone E-mail Text Message
Home Phone No.
Work Phone No.
Cellular Phone No.
E-mail Address
Birth date Age Male ☐ Female ☐
Social Security Number
Married☐ Single☐ Divorced☐ Widowed☐
Employer Position
School

The best time for you for appointments are at: ________ AM/PM The best day of the week is: M T W T R (Circle one or more)
Who make we thank for your referring you:
☐Friend's Name
☐Sign
☐Website / Internet Search
☐Newspaper
☐Television
☐Other
Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

Responsible Party
Address
City State Zip
Responsible Party Social Security Number

DENTAL INSURANCE
PRIMARY DENTAL CARRIER
Insurance Co.
Subscriber Birth date
Subscriber
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

SECONDARY DENTAL CARRIER
Insurance Co.
Subscriber
Subscriber Birth date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of ____________________________________'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

____
Patient Date

____
Parent of Guardian Relationship

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name ____ Birthdate ___________________________ Age _____________

Why are you now seeking dental treatment? ____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now?.. Yes No
2. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ____
3. Have you ever been hospitalized or had a serious illness?... Yes No
   If yes, explain ____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No
5. (Women) Are you pregnant? If so, give due date ____ Yes No
6. Do you use tobacco in any form? If yes, how much? ____ Yes No
7. Do you use alcoholic beverages (more than 2 drinks per day)? .... Yes No
8. Do you have or have you ever had any of the following?

GENERAL		
Tire easily, weakness	Yes	No
Marked weight change	Yes	No
Night sweats	Yes	No
Persistent fever	Yes	No
SKIN		
Eruptions (rash) hives	Yes	No
Change in skin color	Yes	No
EYES		
Visual Change	Yes	No
Glaucoma	Yes	No
EARS		
Loss of hearing	Yes	No
Ringing in ears	Yes	No
NOSE		
Frequent nosebleeds	Yes	No
Sinus problems	Yes	No
THROAT		
Soreness/hoarseness	Yes	No
NERVOUS SYSTEM		
Stroke	Yes	No
Headaches	Yes	No
Convulsions/epilepsy	Yes	No
Numbness/tingling	Yes	No
Dizziness/fainting	Yes	No
Psychiatric treatment	Yes	No
RESPIRATORY		
Tuberculosis	Yes	No
Emphysema	Yes	No
Asthma/hay fever	Yes	No
Persistent cough	Yes	No
Sputum production (Phlegm)	Yes	No
Cough up bloody sputum	Yes	No
Difficulty breathing lying down	Yes	No
ENDOCRINE		
Diabetes	Yes	No
Family history of diabetes	Yes	No
Thyroid condition/goiter	Yes	No
Other ______________________________		

HEART/BLOOD VESSELS		
Rheumatic Fever	Yes	No
Heart Murmur	Yes	No
Chest pain/discomfort	Yes	No
Heart attack/trouble	Yes	No
Shortness of breath	Yes	No
High blood pressure	Yes	No
Congenital heart disease	Yes	No
Artificial heart valve	Yes	No
Pacemaker	Yes	No
Heart surgery	Yes	No
Other _____________________________________		
BONE/MUSCLES		
Arthritis/rheumatism	Yes	No
Artificial joints	Yes	No
DIGESTIVE SYSTEM		
Hepatitis	Yes	No
Jaundice	Yes	No
Ulcers	Yes	No
Change in appetite	Yes	No
Black, bloody or pale stools	Yes	No
URINARY		
Kidney disease	Yes	No
Increase in frequency of urination (night)	Yes	No
Burning on urination	Yes	No
Urethral discharge	Yes	No
Bloody urine	Yes	No
Venereal disease	Yes	No
BLOOD		
Bruise easily	Yes	No
Anemia	Yes	No
Blood transfusion	Yes	No
OTHER		
Radiation therapy	Yes	No
Tumors or growths	Yes	No
Cancer	Yes	No
AIDS	Yes	No

Please complete second page

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies ________________________________		

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/ cold remedies	Yes	No	Aspirin	Yes	No
			Other medication ______________________________		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. ____
2. ____
3. ____
4. ____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain ____

12. Physician's Name ____ Phone __________

13. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain ____

14. Does dental treatment make you nervous? No Slightly Moderately Extremely

15. Date of last dental visit ____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when? ____

17. Do you have or have you ever had any of the following?

MOUTH			**TEETH**		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blister, lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	Shifting of teeth	Yes	No
Difficulty opening or closing jaw	Yes	No	Change in bite	Yes	No

ORAL HYGIENE

Do you use the following?

Brush	Yes	No	How often do you brush _____________________________
Dental floss	Yes	No	Brush is: soft medium hard
Fluoride rinse	Yes	No	

Other ____

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature of patient, parent or guardian ____ Date _______________

Palm Beach Smiles

Michael I. Barr, D.D.S.
650 W. Boynton Beach Blvd., Suite 1
Boynton Beach, FL 33426
561-736-2377

Financial Arrangements

All patients, please read the following…

Payment for services is expected at the time service is provided. Cash and personal checks are accepted. If an extended payment plan is desired, please ask us about your options. MasterCard and VISA credit card payment are also welcome. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance…

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We are out of network for all insurance policies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

____________________________ Print Name

____________________________ Signature & Date

E-mail: mikebarrdds@palmbeach-smiles.com Website: www.palmbeach-smiles.com

Palm Beach Smiles

Aesthetic Dentistry by Michael I. Barr, D.D.S.
650 W. Boynton Beach Blvd., Suite 1
Boynton Beach, FL 33426
561-736-2377

Smile Survey

Our office is conducting a survey of our patients. If you would kindly answer a few questions below, it would be greatly appreciated. ☺

How do you feel about your smile?

____
____
____
____

If you could change anything about your smile, what would it be? (If you had a magic wand!)

____
____
____
____

Is there anything that would keep you from improving your smile? If so, please explain.

____
____
____
____

Are you familiar with how today's dentistry can enhance your smile? **Yes / No**

Would you like to learn more about how you can improve your smile? **Yes / No**

Your name:_______________________________________

Thank You! ☺

E-mail: mikebarrdds@palmbeach-smiles.com Website: www.palmbeach-smiles.com