

Patient Registration Information (CONFIDENTIAL)



Name: _____
First Middle Last Preferred Name

Address: _____
City State Zip code Social Security #

Date of birth: _____ Age: _____ Email Address: _____

Home Phone: _____ Cell: _____ Work: _____

**Mark Preferred Number

Referred by: _____

Responsible Party Information (If under age 18 only)

Name: _____
First Middle Last Date of Birth

Address: _____
City State Zip code Social Security #

Home Phone: _____ Cell: _____ Work: _____

**Mark Preferred Number

Place of Employment: _____ Relationship to Patient: _____

Insurance Information

Name of Insured: _____
First Middle Last Date of birth

Address of Insured: _____
City State Zip code Social Security #

Phone: _____ Place of Employment: _____ Relationship to Patient: _____

Insurance Company: _____ Phone: _____ Member ID: _____

If you have dual insurance

Name of insured: _____
First Middle Last Date of birth

Address of Insured: _____
City State Zip code Social Security #

Phone: _____ Place of Employment: _____ Relationship to Patient: _____

Insurance Company: _____ Phone: _____ Member ID: _____

Emergency Contact Information (Outside of immediate household)

Name: _____ Home Phone: _____ Cell Phone: _____

Financial Responsibility

We will gladly bill your insurance for you and estimate your share at the time of treatment. **Payment for your estimated portion is due at the time of service.** For your convenience we accept the following methods of payment (please check the option your prefer):

Cash or Checks Mastercard or Visa Monthly payments (CARE CREDIT approval required)

I acknowledge that I am financially responsible for all charges and balances over 30 days may incur 1.5% monthly finance charge. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and/or canceled appointments may result in a **\$40 fee**.

I authorize **Hidden Springs Family Dentistry** to bill my insurance company as well as release any information needed to do so and assign benefits to **Robert A. Darke, DDS, PC**.

Signature: _____ Date: _____

Patient Dental History (CONFIDENTIAL)



Primary reason for your visit today? _____

When was your last dental visit? _____ Name of previous dentist: _____

Have your previous dental experiences been favorable? _____ If not, please explain: _____

Reason for changing dentists: _____

Table with 4 columns: Question, Yes, No, Yes, No. Rows include Sensitivity to hot or cold, Root canal treatment, Sensitivity to sweets or sour, Frequent headaches, Sensitivity to pressure/biting, Habitual grinding or clenching of teeth, Bleeding gums while brushing/flossing, Jaw joint pain, Frequently bite cheeks/lips, Clicking or popping of jaw, Sores or lumps in or around your mouth, Pain in ear or side of face, Gum recession, Crooked teeth, Periodontal (gum) treatment, Does food catch between your teeth, Cracked or broken teeth, Orthodontic treatment, Difficult extractions, Discolored teeth.

Medical History

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: _____ Date of last physical: _____

Are you under medical treatment now? _____ If yes, describe: _____

Have you been hospitalized or had a serious illness in the last 3 years? _____ Explain: _____

Do you smoke or use smokeless tobacco? _____ If yes, how often? _____ How many years? _____

Table with 4 columns: Medication/Condition, Y, N, Y, N. Rows include Aids/HIV, Heart Murmur, Anemia, Hepatitis, Angina/Chest pain, Herpes, Artificial joint/Implant, High Blood Pressure, Asthma/resp. problems, Jaundice, Bleeding problems, Kidney Disease, Cancer, Liver Disease, Chemotherapy, Pacemaker, Diabetes, Psychiatric care, Dizziness/Fainting, Sleep Apnea, Easily Winded, Stomach issues/ulcers, Epilepsy/Seizures, Stroke, Emphysema/COPD, Thyroid problems, Glaucoma/Cataracts, Tuberculosis, Heart Attack, Use of CPAP, Heart Disease, Other.

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.

Signature: _____ Date: _____