Dr. Roy Thompson

Comprehensive Family Dentistry

Registration Form

Patient Information

Name

Last ________________ First ________________ Middle________________

Preferred Name ______________________________

Gender   Male   Female

Family Status   Married   Single   Child   Other

Date of Birth______________ Social Security Number __________

Email address___________________________

Home Phone_________________ Cell Phone__________________

Work Phone _________________

Mailing Adress. _________________________

City ___________ State____________ Zip__________

Name of Emergency Contact and Phone number___________________

Name of person or other source referring you to our office_______________

Insurance Information

Name of Insured_____________________ Insured's Date of Birth___________

Insured's Social Security Number _____________

Relationship to Insure   Self   Spouse   Child   Other

Insurance Plan Name_________________ ID# _________ Group# _____

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Consent for Services/ Photography and HIPPA Statement

We are dedicated to helping you maintain and enjoy a healthy smile for a lifetime! We will explain and discuss treatment cost prior to procedures. Treatment recommendations at this office are mad~ to improve your oral health and accomplish your health goals. For your convenience cash, check, debit cards, and all major credit cards are accepted.

Emergency services or procedures accepted and performed without previous arra.ngements are expected to be paid at the time of service. For creditworthy patients we have flexible monthly payment options through a credit company.

Patients with dental insurarite benefits understand that estimates given by this office are not guaranteed by our office oryour dental carrier. It is the patient's responsibility to have knowledge of allowances and restrictions on their insurance policies and the dates their plan is effective. We will make every attempt to help you maximize your benefits. *It is the patient's responsibility for any amounts not covered by your benefits.*

During the course of my treatment photographs will be taken. I authorize that these photographs can be used for diagnostic and teaching purposes.

By signing below, I acknowledge that I have read and understand the above information and have had any specific questions answered. I agree to accept correspondence from this office through any given contact information, including messages. I authorize the office to send my insurance carrier any necessary information about my condition so that prompt and accurate payment can be made. I also authorize my insurance company to make payment directly to this office. This authorization will remain in effect until I notify the office in writing otherwise.

Privacy Statement- This office shares no information with anyone outside the office regarding your dental or medical condition. Only when appropriate for your care will we discuss your treatment with your other medical professionals or authorized family members.

Signature of patient, parent, or guardian (responsible party)

Date: ____________

Relationship to Patient_______________

Person/s whom we may discuss your treatment and health __________________

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Medical Review

Name ______________________________ Are you currently under the care of a physician? Yes No

Physicians name and phone number______________________

Are you currently taking any prescription or over the counter medications? Yes No

Please list any medications and dosages that you are presently taking?

Have you ever been told by your physician to take antibiotics before dental treatment? Yes No

Are you allergic to or have you had any adverse reactions to any of the following:

- ☐ Latex
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Anesthetic (novacaine or lidocaine)

List any allergies you may have that are not listed above: ___________________________________

Do you have any of the following conditions (please mark all that apply)

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Mental Disorder/s
- ☐ Mitra Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ *I have none of the above*

Do you have any conditions or diseases not listed above? Yes No

If so, please list: ____

Women: Are you pregnant? Yes_ No_ Are you taking birth control? Yes No

If you are taking birth control, are you aware that antibiotics may decrease effectiveness? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. have answered all questions to the best of my knowledge. Should further information be needed, my signature below serves as an authorization for other health care providers to release necessary information. I agree to notify the doctor of any change in my health or medications.

Date __________

Doctor Name ___________________

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Dental History

Patient Name ______________________________

What is the reason for your visit today?

____

What was the date of your last dental visit? ____________

Previous dentist, ___________

How often do you brush your teeth? ______ How often do your floss? _______

Have you ever had any of the following :

☐ Orthodontic treatment ☐ Oral Surgery ☐ Periodontal (gum) treatment

☐ Your bite adjusted or teeth ground ☐ A mouth guard or bite plate

☐ Any major accident involving your face, teeth, or jaws

Do you experience any of the following:

☐ Cold sensitivity ☐ Sweet sensitivity ☐ Hot sensitivity

☐ Biting or chewing sensitivity ☐ Broken tooth/teeth Gum soreness ☐ Dry mouth

Do you use tobacco products? If so, how long and what products_________________________

How long do you expect to keep your teeth?__________________________

Do you feel nervous about dental treatment? Yes No

Have you ever had an upsetting or unpleasant dental experience? Yes No

If yes, please explain

____

____

Would you like your smile to look different or better? Yes No

What would you like your teeth to be like in 5-10 years from now?

____

____

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FINANCIAL GUIDELINES

Thank you for choosing Dr. Roy Thompson's Office for your dental needs. We understand that everyone's financial situation is
different. For this reason, we have worked hard to provide you with a variety of payment options to help you receive the
dental care you want and deserve, with respect to your budget. We are always available to address any questions or concerns
you may have. Please choose one of the following options:

1. PAY AS YOU GO

Our "Pay as you go" option allows you to be in control of your insurance benefits, by paying fully at each appointment for treatment and by being reimbursed directly by your insurance company. This will enable you to keep personal records of all insurance reimbursements, all dental transactions, to track maximum allowable benefits, be more aware of what your plan covers, and what restrictions and limitations it does not cover. You will never have to worry about having an outstanding account balance with us. We will make sure your insurance claims will still be filed, and that payment will go directly to you. When insurance companies reimburse patients, payment usually takes about 7-10 business days, especially if your plan accepts electronic dental claims. If required, at each appointment we will send electronic claims for you. *This option comes with a courtesy reduction for fees in excess of $300. Cash/checks prepayment is a 5% reduction and Credit / debit card prepayment is a 3% reduction.

2. ASSIGNMENT OF BENEFITS

Our "Assignment of benefits" options offers you the convenience of using your dental benefits as a form of direct payment by assigning payment from your dental insurance company direct to Dr. Roy Thompson. Your deductible and estimated co payments will be collected at the time of scheduling. Please be reminded that your dental insurance is an agreement between your insurance company and you. This means you are responsible for any service fees or balances that may not be covered by you dental benefits plan. Choosing Dr. Roy Thompson to submit electronic claims on your behalf requires you to leave a valid credit card number on file (MasterCard, Visa, Discover, or American Express)

as a precondition. Balances not covered by your dental insurance will be charged directly to your credit card on the day the insurance benefit check is posted to your account or within 30 days of your treatment if there is a delay in payment by the insurance company. If you decline leaving your credit card on file, you miss the courtesy of Dr. Roy Thompson accepting direct payments from your insurance company on your behalf and you will be responsible for the payment in full at the time of scheduling each appointment. Please fill out and complete our credit card authorization form. It will be kept strictly confidential and will be used only under agreed terms.

3. INTEREST FREE OR LONG TERM FINANCING

Our "Interest free or Long Term Financing" option offers you an arrangement with our financial partner. Upon approval, you can receive a 6-24 month *interest free* or *long term* loan, with no down payment or collateral, low monthly payments. Pleaseinform us if you would like assistance in the application process.

____________________ ____________________

DOCTOR NAME **DATE**