Broadway Smiles
EXCEPTIONAL DENTISTRY

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date _____

Patient's Name _____
Last

_____
First Middle Initial

Sex ☐ M ☐ F Birthdate _____ Age _____

Social Security # _____ Marital Status _____

Street Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____

Cell# _____

Email _____

HOW DID YOU HEAR ABOUT US? _____

WHO MAY WE THANK FOR REFERRING YOU?

_____

If patient is a minor (under 18), give parent or guardian name:

_____

If you are 18 and older, you are responsible for any deductibles and co-insurance amounts at the time of service, unless previous arrangements have been made with the Office Manager.

ACCOUNT INFORMATION

Responsible Party Self _____ Parent _____ Spouse _____

Last Name _____

First Name _____

Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____

Cell# _____

SS# _____ Birthdate _____

Email _____

DENTAL INSURANCE

Insured's Name _____

Insurance Co. _____
Insurance Address _____

Insured's Employer _____

SS# _____ Birthdate _____

Group# _____

Secondary Insurance will need to be submitted by the patient once the Explanation of Benefits is received from your primary insurance.

EMERGENCY CONTACT

Whom should we contact? _____

Relation _____

Home # (_____) _____

Work#: (_____) _____

Cell Phone# (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone # (_____) _____

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. I am responsible to pay my estimated coinsurance and deductible at the time of service. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent if child) _____ Date: _____ Dentist Signature: _____

Halek and Rathburn Partnership DBA Broadway Smiles

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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MEDICAL HISTORY

Are you taking any of the following medications?

- ☐ Stimulants
- ☐ Pain Killers (Including Aspirin)
- ☐ Muscle Relaxers
- ☐ Bisphosphonates
- ☐ High Blood Pressure Pills
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ Insulin

Other(s), please list: _____

Have you had or do you have any of the following medical conditions?

High/Low Blood Pressure	☐Y ☐N	Stroke	☐Y ☐N	Arthritis/Gout	☐Y ☐N
Heart Murmir	☐Y ☐N	Kidney Disease	☐Y ☐N	Detached Retina/Glaucoma	☐Y ☐N
Mitral Valve Prolapse	☐Y ☐N	Diabetes	☐Y ☐N	Auto-Immune Disease	☐Y ☐N
Pacemaker	☐Y ☐N	Hypoglycemia	☐Y ☐N	AIDS (HIV)	☐Y ☐N
Heart Attack/Surgery	☐Y ☐N	Liver Disease/Jaundice	☐Y ☐N	Cold Sores (lip)	☐Y ☐N
Rheumatic Fever	☐Y ☐N	Seasonal Allergies	☐Y ☐N	Gastroesophageal Reflux	☐Y ☐N
Congestive Heart Failure	☐Y ☐N	Sinus/Nasal Problems	☐Y ☐N	Cancer	☐Y ☐N
Chest Pain/Angina	☐Y ☐N	Asthma	☐Y ☐N	Radiation Treatment	☐Y ☐N
Artificial Heart Valve	☐Y ☐N	Lung Disease	☐Y ☐N	Chermotherapy	☐Y ☐N
Artificail Joints/Hip	☐Y ☐N	Tuberculosis	☐Y ☐N	Osteoporosis	☐Y ☐N
Anemia	☐Y ☐N	Chronic Cough	☐Y ☐N	MRSA	☐Y ☐N
Bleeding or Clotting Disorder	☐Y ☐N	Sleep Apnea (CPAP)	☐Y ☐N	Psychiatric Care	☐Y ☐N
Fainting or Dizziness	☐Y ☐N	Hepatitis A or B or C	☐Y ☐N	Celiac Disease	☐Y ☐N
Epilepsy or Seizures	☐Y ☐N	Thyroid Disease/Goiter	☐Y ☐N	Other	☐Y ☐N
Multiple Selerosis	☐Y ☐N	Sjogren's Disease	☐Y ☐N		

Are you allergic to any of the following?

Penicillin	☐Y ☐N	Local Anesthetic	☐Y ☐N
Codeine	☐Y ☐N	Sedative	☐Y ☐N
Sulfa	☐Y ☐N	Aspirin	☐Y ☐N
Latex	☐Y ☐N	Ibuprofen	☐Y ☐N
Iodine	☐Y ☐N	Shellfish	☐Y ☐N

Please List Other Allergies

_____

_____

_____

_____

Chemical Dependency

Smoking (any form)	☐Y ☐N
Chewing Tobacco	☐Y ☐N
History of Alcohol or Drug Dependency?	☐Y ☐N

Women

Are you taking Birth Control? ☐Yes ☐No

If YES what type? ☐Pills ☐Shots ☐Patch ☐Norplant

Are you pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

Are you taking hormone replacements? (HRT) ☐Yes ☐No

With regards to oral contraceptives it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is complete. Please consult with you physician for further guidance.

Signature of Patient or Parent If Minor **Date**

- We invite you to discuss with us any questions regarding our services. The best Dental Health Services are based on a mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient or Parent If Minor **Date**

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DENTAL HISTORY

Name: _____ BirthDate: _____

What is the reason for your visit today? _____

Last Dental Cleaning: _____ Last Dental Visit: _____

Last Routine 4-BW X-rays: _____ Last Full Mouth X-rays: _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name: _____

Address: _____ State: _____ Zip: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (waterpick, electric toothbrush, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No
Sweet? ☐ Yes ☐ No
Biting or Chewing? ☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss ☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, expecially in the morning? ☐ Yes ☐ No
Snore or have any other sleeping disorders? ☐ Yes ☐ No
Smoke/Chew tobacco or use other tobacco products? (marijuana) ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Pediodontal treatment? ☐ Yes ☐ No
Your teeth ground or bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause: _____

Have you ever experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain? (joint, ear, side of face) ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of mouth? ☐ Yes ☐ No
Headaches, neckaches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders)? ☐ Yes ☐ No
Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No
Are you apprehensive about dental treatment? ☐ Yes ☐ No

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

- Fear of Pain: _____
- Cost of Treatment: _____
- Lack of Concern: _____
- Missing work time: _____

If you could change anything about your smile it would be:

☐ Make them brighter
☐ Close spaces
☐ Repair chipped teeth
☐ Alterative to a denture
☐ Get a smile makeover
☐ Make them straighter
☐ Replace metal fillings with tooth color fillings
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Nothing, I love it.

On a scale of 1-10, with 1- being the highest

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe: _____

_____

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FINANCIAL POLICY

Welcome to our office! We are delighted that you have chosen our dental practice to guide you in maintaining excellent oral health. It is our mission to provide comprehensive, technologically superior dental care in a safe, comfortable and professional environment. In return, we ask for your commitment to your dental health. Please feel free to ask questions to clarify any procedure, treatment plan or payment expectation.

No Insurance Coverage
Payment is due at the time of service unless financial arrangements are made with the front office personnel. Individuals who are 18 years of age and older are responsible for payment at the time of service. Through Care Credit, we offer monthly payment plans with approved credit.

_____

Insurance
We encourage you to become familiar with your policy's exclusions, deductibles and required co-payments. As a courtesy, we will process your insurance claims. Insurance is a contract between you and your insurance company. We are not party to this contract. Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your benefits and eligibility. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient/responsible party and that he or she is personally responsible for payment of all dental services. We cannot file an insurance claim on your behalf if the correct insurance policy information is not provided to us. All patients will be expected to pay all estimated co-pays, deductibles and non-covered portions of dental procedures at the time of service. If your insurance company does not respond to the submission of the claim within 90 days, all charges are required to be paid by the patient or responsible party. We are exclusively an in-network provider for Delta Dental Premier Plans.

_____

Updating of Records
To maintain the quality and standard of care we are recognized for, we require all records and/or applicable radiographs be updated at least every 5 years. We do our best to work within your insurance plan's parameters and frequency limitations, but we do not let insurance companies dictate the health of your mouth and will update full mouth radiographs and comprehensive examinations at least every 5 years and is the doctor's discretion whether to update more often. Payment for these services are the responsibility of the patient/responsible party regardless of insurance plan limitations and coverage.

_____

Cancellation Notice and Missed Appointment Fee
If you must change an appointment, please give us 48 business hours of notice. A $50 per scheduled hour no show/ late cancellation fee may be charged. Patients with more than 3 missed appointments and/or late cancellations may be asked to transfer records to another doctor.

_____

Returned or NSF Checks
There will be a $20 service charge on all returned/NSF checks and additional charges may apply if the account is turned over to collections.

_____

Past Due Accounts
The responsible party and/or patient hereby understands that if the account becomes delinquent, we will take necessary steps to collect this debt. If we have to turn over your account to a collection agency, you agree to pay all court costs and attorney fees to collection of all past due amounts owed, including cost of collection agency fees. Accounts 30 days or more past due are subject to a $5 late fee.

_____

Divorce
In case of divorce or separation, the party responsible for the account prior to the relationship dissolution remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____

Patient's Name _____ Date _____

Responsible Party's Signature _____