**Registration Form**

## Patient Information

Patient Name: ______________________________________________ Date:____________

Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___________

Social Security #: __________________________ Birth Date:__________________________

Phone (Home): _____________ (Work): _____________ Ext:_____ (Cell): _____________

Best time to call:___________ Email: __________________________

Address: ______________________________________________________________

Street Apartment #

______________________________________________________________

City State Zip Code

## Health Information

Date of Last Dental Visit: ______________ Reason for this visit:____________________________

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS
☐ Allergies ___________
___________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _______________

☐ None of The Above

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:__________________________________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:__________________________________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  Name of Physician: ______________________________________ Phone:_______________
- Do you have a preferred pharmacy? ☐ Yes ☐ No
  Name of Pharmacist:_____________ Phone:_____________ Address: ______________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:__________________________________________________________
- Medication Name, Dose, Reason for taking: _____________________________________________

______________________________________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________________________________ Date: _______________

**Signature of patient, parent or guardian**

______________________________________________________ Date: _______________

Signature of Dentist that reviewed Medical History

## Referral Information

Whom may we thank for referring you to our practice? ______________________________________

# Written Financial Policy

**Thank you for choosing Vast Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.**

**Payment Options:**
**You can choose from:**
**Cash, Visa, MasterCard, American Express or Discover Card**

**We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $300 or more.**

**Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card and Lending Club**
**-Allow you to pay over time**
**-Vast Dental do not accept checks**

**Please note:**
*** Vast Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.**
*** For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1000 or more, a 10% deposit is required to secure your initial treatment appointment.**
*** For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]**
*** A fee of $25 is charged for patients who miss or cancel more than 1 times in a calendar year without 48-hour notice.**
*** If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.**
*** Unpaid balances over 90 days will be sent to collection.**

__________________________________________________
**Patient, Parent or Guardian Signature**

__________________________________________________
**Patient Name (Please Print)**

[1]Subject to credit approval
[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

# Consent

**INSURANCE ASSIGNMENT AND RELEASE:**
I certify that I, and/or my dependents have insurance coverage with the insurance company provided to the office and assign directly to Vast Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named dentist may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or two years from the date of this signature.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

**DENTAL CONSENT:**
I hereby authorize Dr. Hoang and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medications, antibiotics, local anesthetic, and expose radiographs that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care. I realize that it is mandatory that I follow any instructions given by my dentist and/or his/her associates and take any medications as directed.

I fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, local anesthetic, and any dental treatment. The most common risks can include, but are not limited to:
Bleeding, swelling, bruising, discomfort, stiff jaw, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

**I have read the above conditions, dental consent, and agree to their content.**

________________________________________ **Date**: _____________ **Relationship to Patient:** ________________
**Signature of patient, parent or guardian**

# Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

________________________________________ **Date**: _____________ **Relationship to Patient:** ________________
**Signature of patient, parent or guardian**