"NICE NICE" DENTAL

SO NICE WE SAID IT TWICE

We're so glad you chose us to be your family dentist!
Please take a few minutes to fill out this registration form, and let us know if you have any questions.

Patient Information

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email Address: _____

The best way to contact me is on my ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Occupation: _____

If Retired, please state what your occupation was: _____

Male ☐ Female ☐ Date of Birth: _____ Social Security Number: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married (Spouses Name _____)

If Student, Name of School: _____ City/State: _____ ☐ FT ☐ PT

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you? (We love referrals!) _____

Insurance Information

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Employer Address: _____ City: _____ State: _____ Zip _____

Insurance Company: _____ Group #: _____ ID#: _____

Ins Co. Address: _____ Ins Co. Phone: (____) _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No (If yes, please complete the following)

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Employer Address: _____ City: _____ State: _____ Zip _____

Insurance Company: _____ Group #: _____ ID#: _____

Ins Co. Address: _____ Ins Co. Phone: (____) _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
10 Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
12. Do you / would you have any problems chewing gum? _____	☐	☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
15. Are your teeth crowding or developing spaces? _____	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
18. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
20. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years? _____	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
25. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
27. Do you frequently get food caught between any teeth? _____	☐	☐
GUM AND BONE		
28. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
31. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
32. Have you ever experienced gum recession? _____	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
34. Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health (i.e. fever, new cough) __	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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OFFICE PAYMENT POLICY

We attempt to keep our fees at a fair level that reflects the quality of care provided in our office; therefore, ***payment is due at the time services are rendered.*** In order to make it easier for you to pay in full at that time, the options we offer are: cash, Visa, Master Card, personal check and Care Credit.

When insurance is involved, your deductible *(if applicable)* and estimated co-payment for services rendered at the time of appointment are required. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments scheduled.

If you have insurance, please keep in mind that insurance is designed to *defray* the costs of dental care by covering only a portion or percentage of the bill. The benefits that you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company and not your dental office. As a courtesy to our patients, we will file your insurance claims, however, ***your total balance in our office is always your responsibility.*** We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us. However, we have no way to guarantee the actual terms of your insurance policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier. Our office will make every effort to help you understand and make the most of your dental insurance benefits.

Insurance usually pays within 45 to 60 days; after that point, you will be responsible for the balance.

We respectfully ask that you give us a 24 hour notice if you are unable to keep your scheduled appointment so that we have time to schedule another patient in need of care. If you do not show up for your scheduled appointment, a $50.00 charge will be applied to your account.

I have read, understand and agree to adhere to the financial policies outlined above.

Name: _____ Date: _____

(Name of Patient or Person responsible for any financial obligation incurred)

9772 West Yearling Road, Suite A-1680 | Peoria, Arizona 85383

Direct: 623.825.0616 | Fax: 623.825.0186 | Email: hello@nicenicedental.com

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HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure the personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support our full access to your personal dental records as provided by the Arizona Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These Entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

_____ _____

Print Patient / Parent / Guardian's Name *Signature*

_____ _____

Witness Signature *Date*

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Valued Patient:
The matter of appearing for scheduled appointments is a real concern for us. We know that your time is valuable and recognize that no one likes to be hounded to acknowledge a scheduled appointment.

Below please note the best way to contact you regarding your appointments.

Cell phone _____ #_____

Home phone _____ #_____

Text message _____ #_____

Other contact _____

DO NOT want a courtesy call _____

I will respond to messages via the above contact preference.
I understand that there will be a $25 charge for missed appointments.
I agree to pay this fee if I do not speak to the office 48 hours prior to my appointment. (Messages cannot be left with Voice Mail)

_____

Signature Date