

# PATIENT REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ FT Student: Y N If yes, Where: \_\_\_\_\_

Whom May We Thank for Referring You to our Office? \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

RESIDENCE Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAILING ADDRESS Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ May we Text you Appointment Reminders: YES NO

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ Phone Number \_\_\_\_\_

## PATIENT CONTACT INFORMATION

HOME PH. \_\_\_\_\_ WORK PH. \_\_\_\_\_

CELL PH. \_\_\_\_\_ May we text reminders Y N

E-MAIL \_\_\_\_\_

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORK PH. \_\_\_\_\_

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

## If you have secondary dental insurance coverage, complete this for the second coverage.

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance cover with the above named insurance company and assign directly to Dr. Jodi Danna all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This assignment and release will apply to any new insurance provided to the office in the future

Dr. Jodi Danna may use my health care information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_

Patient Name \_\_\_\_\_

## DENTAL HISTORY

Please check any of the following that apply to you.

- Sensitivity (hot, cold, sweet)
- Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, chipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Gum treatments

What is the most important thing to you about your dental visit today?

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco?

How much? For how long?

If I could change my smile, I would:

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 – 10, with 10 being the highest rating:

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

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

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

## MEDICAL HISTORY

Please check any of the following that apply to you:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction                | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding            | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions              | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions<br>(Congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur                  | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery                 | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                   | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                   | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> HPV Positive      |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                   | <input type="checkbox"/> Radiation (head/neck)  | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Respiratory Problems   |  |

Do you have any of the following drug allergies?

- Aspirin
- Sulfa
- Nitrous Oxide
- Percodan
- Local Anesthetic
- Codeine
- Erythromycin
- Valium
- Penicillin
- Latex
- Other

Are you under a physician's care? What for?

Are you taking any medications? What?

Family Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Is there any other medical or dental information we should know about? \_\_\_\_\_

Patient Signature (Parent of Child) \_\_\_\_\_

Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_



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**JODI D. DANNA, D.D.S., P.C.**

**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}

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**For Office Use Only**

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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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# Office Orientation and Financial Information

We are pleased that you have chosen our office for your dental needs. Below is information to assist you in understanding our services and to help familiarize you with our office. Our office hours are from 7:00 AM to 3:00 PM on Tuesday, Wednesday and Thursday and 9:00am to 1:00pm on Friday.

\_\_\_\_\_ **Appointment Cancellation/Reschedule Information:** If you are ever unable to keep an appointment you have scheduled with us, please notify us at least 24 hours (no less than 1 business days) in advance. This allows us the opportunity to see another patient, who may wish to fill that open time. We reserve the right to charge a \$50 fee for all missed appointments and short notice cancellations. If a history of short notice cancellations or “no shows” has been established, you may be required to pre-pay for your dental visits before being rescheduled. You can email us 24 hours in advance at [Amanda@DannaSmile.com](mailto:Amanda@DannaSmile.com). **We respect your time** and ask that you do the same with ours. Our office will call to remind you about your appointment 1-2 days ahead of your scheduled appointment.

**Dental Emergencies:** Please call our office for further instructions in emergency situations after office hours. Press 3 when the message comes on and Dr. Danna will be paged. In some instances it might take 30-45 minutes for your page to reach Dr. Danna. Please leave all numbers at which you can be reached.

**Dental Treatment:** Beyond our most calculated efforts, further necessary treatment may arise during a dental procedure that was not originally diagnosed. This treatment will incur additional fees that you will be responsible for. Should this situation arise, Dr. Danna will inform you of these changes.

**Insurance:** Our office is *out of network* on all insurance plans. With our extensive knowledge and experience, our insurance experts can help you maximize your insurance benefits. However, it is important to remember that the insurance is a contract between you and the insurance company. We are happy to assist you in following up with your insurance company, writing appeals and necessary narratives for payment, this is offered as a courtesy to you.

**Financial Payment Options:** Please initial your choice of payment option.

\_\_\_\_\_ **Option 1:** Payment in full at the start of treatment with a 5% accounting adjustment. (Cash, Check, Credit Card) for any charge over \$400. We will file your insurance as a courtesy to you and the insurance company will reimburse you directly for your services.

\_\_\_\_\_ **Option 2:** Patient financing through our partnership with Care Credit. 3, 6, or 12 Months Interest Free. We also offer extended financing up to 48 months for a low interest rate.

\_\_\_\_\_ **Option 3:** We will file and accept Assignment of Benefits from your Insurance Company and You are responsible for your **estimated** portion when services are rendered. This option requires a credit card authorization be placed on file with us so that any remaining balance after your insurance has paid will be cleared from your account. **No calls will be made prior to running any balance due.** Please note that insurance balances not paid within 60 days of the date of service will be run on the credit card on file. Please understand that your insurance is a contract between you and the insurance company, filed as a courtesy to you, by our office. Unfortunately, if you are covered by **Delta Dental or any other insurance company** that does not pay us directly, this will not be an available option for you.

\_\_\_\_\_ **Option 4: In Office Savings Plan** – Payment directly to the dental practice for a period of three months in advance of dental care.

\_\_\_\_\_  
Patient Signature (Parent or Guardian, if patient is under the age of 18)

**“Easy Pay”**

**Credit Card Authorization**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Credit Card:    MC    VISA

Card Number \_\_\_\_\_

Expiration Date: \_\_\_\_\_

I authorize Jodi D. Danna, D.D.S. to charge the above credit card should any balance be remaining on my account after my insurance company completes processing of my claims. **I understand that my insurance is a contract between myself and my insurance company and that Dr. Danna’s staff is filing the claim as a courtesy to me. I understand that I am fully responsible for my account regardless of insurance coverage.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Staff Signature

**Attach Credit Card Imprint**

**AUTO-PAY**