

# American Dental Care

60 Wolf Creek Blvd, Dover, DE-19901

Ph: 302-734-7634

F: 302-734-7816

## PATIENT REGISTRATION FORM

### GENERAL INFORMATION

**Date\*** \_\_\_\_\_ **Patient's Social Security Number\*** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial (optional) \_\_\_\_\_ Last Name \_\_\_\_\_

**Date of Birth\*** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Gender M \_\_\_\_ F \_\_\_\_

Address \_\_\_\_\_

Number \_\_\_\_\_ Street \_\_\_\_\_ Apt. # (If applicable) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_

**E-mail\*** \_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Spouse's Name (if applicable) \_\_\_\_\_

**Name of Responsible Party\*** \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Responsible Party Date of Birth\*** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Responsible Party SSN\*** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### DENTAL INSURANCE

**Primary Insurance Company\*** \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

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

Insured Employer: \_\_\_\_\_ Group # \_\_\_\_\_

**Primary Insurance Holder's Name\*** \_\_\_\_\_

**Insurance Holder's Birthday\*** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Insurance Holder's SSN\*** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Insured's ID #\*** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Is patient covered by additional insurance? Y \_\_\_\_ N \_\_\_\_

**Secondary Insurance Company\*** \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

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

Insured Employer: \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance Holder's Name\*** \_\_\_\_\_

**Insurance Holder's Birthday\*** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Insurance Holder's SSN\*** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Insured's ID\* #** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Payment is due in full at the time of treatment: unless prior arrangements have been approved.**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment of examination rendered, to my insurance company.

Signature of Patient, Parent, Guardian or Representative \_\_\_\_\_

Please Print Name \_\_\_\_\_

Date \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

### EMERGENCY INFORMATION

In case of an emergency, contact:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

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## DENTAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No

Taking oral contraceptives?  Yes  No

Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

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

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker          | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments  | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss    | <input type="radio"/> Yes <input type="radio"/> No |                            |  |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

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## Written Financial Policy

Thank you for choosing American Dental Care. 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, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options from Care Credit Healthcare Credit Card
  - o Allow you to pay over time
  - o No annual fees or pre-payment penalties

Please note:

American Dental Care LLC requires payment at the beginning of your treatment.

For patients with dental insurance we are happy to work with your insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. (For in-network benefits only). You are responsible for paying your co-pays and deductible at the time of service. Any remaining balance after insurance reimbursement is your responsibility

### Appointment Agreement:

At American Dental Care, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 business hours, you will be subject to a \$45 late cancellation charge. Each patient must confirm or cancel their scheduled appointment.

By signing below, I agree to fulfill my obligation as a patient at American Dental Care and agree to the "broken appointment" fee should I not give proper notification.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)