PATIENT REGISTRATION & HEALTH HISTORY FORM

Please complete the following confidential information:

How did you hear about our office? _____

Patient or responsible party, if patient is a minor

Name _____ Home Phone: (____)_____
First Name Initial Last Name

Address: _____
Street City State Zip

Social Security #_____ Date of Birth: _____

Employer_____ Work Phone & Ext: _____

Occupation: _____ Business Address: _____
City, State, Zip

Cell Phone: _____ Driver's License No. _____

Email Address: _____

Spouse

Name: _____ Home Phone: (____)_____
First Name Initial Last Name

Address: _____
Street City State Zip

Social Security #_____ Date of Birth: _____

Employer:_____ Work Phone & Ext: _____

Occupation: _____ Business Address: _____
City, State, Zip

Cell Phone: _____ Driver's License No. _____

Child (if child is patient)

Name _____ **Home Phone:** _(____)_____

Address: _____
City, State, Zip

Date of Birth: _____ Age _____ Sex _____ School _____City _____ Grade _____

Dental Insurance

Primary Insurance Company: _____ Address:_____

Employee: _____ Social Security #:____-___-_____ Member # :_____ Group #: _____

Secondary Insurance Company: _____ Address:_____

Employee: _____ Social Security #:____-___-_____ Member # :_____ Group #: _____

In Case of emergency contact:

Name: _____

Address: _____ **Phone #:** (____)_____

Is another member of your family a patient at our practice? Yes_____ No _____ Name: _____

NOTES: CC:

MEDICAL AND DENTAL HEALTH HISTORY

1. Are you experiencing dental pain or discomfort? Yes __ No __
2. Are you in good health? Yes __ No __
3. Has there been a change in your general health within the past year? Yes __ No __
4. Are you under the care of a physician? Yes __ No __
   If so, what condition (s) is being treated?_____
   Physician's Name _____Phone #_____
   Address: _____
5. Have you been hospitalized or had a serious operation or illness within the last 5 years?
6. Do you have or have you had any of the following diseases or problems? Please circle all that apply.

Heart Failure		Diabetes		Emphysema	
Heart Disease or Attack		Thyroid Disease		Cough	
Angina Pectosis		High Blood Pressure		Tuberculosis (TB)	
X-ray or Cobalt Treatment		Chemotherapy		Asthma	
Sickle Cell Disease		Arthritis		Sinus Trouble	
Congenital Heart Lesions		Cortisone Medicine		Allergies or Hives	
Psychiatric Treatment		Heart Murmur		Glaucoma	
Scarlet Fever		Mitral Valve Prolapse		Artificial Joint	
Artificial Heart Valve		Pain In Jaw Joints		Anemia	
Fainting or Dizzy Spells		Epilepsy / Seizures		Heart pacemaker	
Heart Surgery		Stroke		Kidney Trouble	
HIV Positive		Cold Sores		AIDS	
STD or VD (Syphilis or Gonorrhea)		Ulcers		Bruise Easily	
Hepatitis A (Infectious)		Blood Transfusion		Rheumatic Fever	
Hepatitis B (Serus)		Liver Disease		Hay Fever	
Hepatitis C				Nervousness	

7. Are you taking any drug or medicine?_____ If so, what _____
8. Are you allergic or have you reacted adversely to any drugs or medicines? Yes __ No __
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in chest? Yes __ No __
10. Do your ankles swell during the day? Yes __ No __
11. Have you had any serious trouble associated with previous dental treatment? Yes __ No __
    If so, please explain_____
12. Have you had abnormal bleeding associated with previous dental treatment? Yes __ No __
13. Do you have a disease, condition or problem not listed above that you think I should know? Yes __ No __
    If so, please explain _____

For Women Only – Are You Pregnant Yes __ No __

If yes, what month are you? _____

Are you taking birth control pills? Yes __ No __

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs or any other diagnostic aids, deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize the office to transmit any and all information necessary to my insurance company for the means of payment by electronic or other means. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent(s) is mine, due and payable at the time of services rendered. If for any reason my account becomes not current, I will pay any legal fees the office incurs to collect said fees.

Signature of Patient, Parent of Responsible Party: _____

Relationship:_____Date: _____ Reviewed _____

Earl R Marrow III D.M.D.
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IMPORTANT; PLEASE READ & SIGN BELOW.

Financial Policy

To avoid any misunderstanding between our office and our patients, we have created a new financial policy and consent-for-treatment form.

General Policy for non-Insurance Patients
Payment is due in full on the day you receive dental services. We do not bill for these services. We accept cash, checks, Visa and MasterCard.
If you are having crowns, veneers, mouth guards or other work that must be sent to a dental lab, we require 50% deposit on the day impressions are taken. At your final appointment to receive your crowns, veneers, etc., we will ask you for final payment in full.

Dental Insurance
As a courtesy to all patients, we will verify your dental insurance. Since we administer so many different plans it is the patient's responsibility to know their Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as a missing tooth clause, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis, and x-rays etc. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, or MasterCard. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment Financing Program.

General Policy for Insurance Patients
A. With the exception of some preventative procedure such as cleanings and x-rays, your dental insurance company will not fully cover the cost of treatment. You are responsible for the portion they do not cover, payable on the day your receive treatment.
B. Resin-Based Composite restorations (fillings)- Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment-amalgam (silver/mercury based restoration). For the best of our patients, we recommend and we place *only* composite based (white) fillings. The difference is usually about $50-$100 per filling and the patient would be responsible for the difference in cost. Please ask our front desk if you have any more questions about composite-based fillings.
C. Most dental insurance plans have a maximum yearly benefit of $1000, while some plans may be more. We cannot submit work done in one calendar year for the next.
D. Most dental plans have a deductible that you must pay each year, typically $50. Usually the deductible does not apply to preventive work.

Financial Charges: All returned checks are subject to a $25 fee. All balances of 60 days are subject to interest in the amount of 1.5% per month mandated by state law. We reserve the right to charge a $25.00 late charge toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau.
Past Due Accounts: In the event that your account is turned over to a collection agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.
Missed Appointment Fee: Please note that there is a missed appointment fee of $25.00 per half hour for all appointments not given at least 48 business hours' notice. Please give us a call in advance if you need to reschedule or cancel your appointment.
Transferring Records: You will need to request in writing if you would like us to mail, fax, e-mail, etc. any part of your records with Earl R Marrow III D.M.D. We need at least 2 working days in advance to prepare your records to be transferred. We need at least 5 business days, if your record is more that two years old.

I HAVE READ AND AGREE TO THE FINANCIAL POLICIES OF EARL R. MARROW, III, D.M.D. AND KATE CROWLEY, D.M.D. I UNDERSTAND THAT ANY PORTION THAT IS NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY. THIS CONSENT AND AGREEMENT WILL REMAIN IN EFFECT AS LONG AS PATIENT REMAINS IN OUR PRACTICE.

Signature:_____ Date: _____

Privacy Practices Acknowledgement

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

Patient Name_____
(Please Print)

Signature _____

Birthdate _____

Date _____