Skees Family Dentistry
1370 Veterans Pkwy Ste1500
Clarksville, IN 47129

New Patient Registration

Patient Information

Name _____ Today's Date _____

Address _____ City _____ State_____ Zip_____

SSN#_____ Birth Date_____ Sex: M___ F___

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

Preferred Method of Communication: Phone___ H, W, C; Email__; Text__

Occupation_____ Employer_____

If you are completing this form for another person, what is your relationship to that person? _____

Please circle one of the following for each question below:

Y=Yes N= No DK= Don't know

Do you have any of the following diseases or problems:

Active Tuberculosis?.....Y N DK

Persistent Cough greater than a 3 week period? ……Y N DK

Cough that produces blood? ……Y N DK

Been exposed to anyone with tuberculosis? ……Y N DK

If you answered yes to any of the above 4 questions, please stop and return this form to the receptionist.

Emergency Contact Information

Name _____ Relationship _____

Address _____City _____ State _____ Zip_____

Home Phone _____Work Phone _____ Cell phone_____

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Insurance Information

Insured's Name _____Insurance Company Name _____

Address _____City_____State_____ZIP_____

Insured's Employer _____ Group #_____

Insured's SS# _____Insured's birth date _____

Dental History

Reason for Visit_____

Date of last dental visit _____Date of last dental x-rays_____

What was done at that time? _____

Please Circle one of the following for each question below:

Do your gums bleed when you brush or floss? ……Y N DK

Are your teeth sensitive to cold, hot, sweet, or pressure?.....Y N DK

If yes, which of the above? _____

Does food or floss catch between your teeth?..... Y N DK

Is your mouth dry? ……..…….. Y N DK

Have you had any periodontal (gum) disease? …….. Y N DK

If yes, for how long?_____

Have you ever had orthodontic (braces) treatment?..... Y N DK

Have you had any problems with previous dental treatment?.....Y N DK

Is your home water supply fluoridated? ……..……. Y N DK

Do you drink bottled or filtered water? ……Y N DK

Are you currently experiencing dental pain or discomfort?.....Y N DK

Do you have earaches or neck pains? ……Y N DK

Do you have any clicking, popping, or discomfort in the jaw? ……...……..Y N DK

Do you brux or grind your teeth?.....Y N DK

Do you have sores or ulcers in your mouth?.....Y N DK

Do you wear dentures or partials?.....Y N DK

Do you participate in active recreational activities?.....Y N DK

Have you ever had any serious injury to your head or mouth?.....Y N DK

Are you apprehensive about dental treatment?.....Y N DK

If yes, then why?_____

Any other dental issues that your dentist may need to know?_____

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Medical History

Are you now under the care of a physician? ……..Y N DK

Physician Name _____Physician Phone Number _____

Address _____City_____State_____ZIP_____

Date of Last Physician Visit _____Reason_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?_____

If yes, what was it? _____

Please circle one of the following for each question below:

-Joint Replacement: Have you had an orthopedic total joint replacement?

(hip, knee, elbow, finger) ……..**Y N DK**

If yes, have you had any complications? _____Date of procedure: _____

Antibiotic prophylaxis is no longer recommended for joint replacements, unless you experienced complications after procedure.

-Are you taking or scheduled to begin taking any medications for osteoporosis or Paget's disease? ……**Y N DK**

If yes, which one : Alendronate (Fosamax) or Risedronate (Actonel) or other?

-Since 2001, were you treated or are you presently being treated or scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastic cancer? ……..……**Y N DK**

-Date treatment began (begins)_____

-Do you use controlled substances (drugs not prescribed)……**Y N DK**

-Do you use tobacco (smoking, snuff, chew, bidis)? ……**Y N DK**

If yes, how interested are you in stopping?.....**Very/Somewhat/Not Interested**

-Do you drink alcoholic beverages?.....**Y N DK**

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY

Are you pregnant? ……Y N DK

If yes, number of weeks? _____

Are you taking birth control pills or hormone replacement?.....Y N DK

Are you nursing? ……..Y N DK

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Are you allergic to or have any reaction to any of the following:

(If yes, specify the type of reaction)

Local Anesthetics _____Y N DK

Aspirin_____Y N DK

Penicillin or other antibiotics _____Y N DK

Barbituate, sedatives or sleeping pills _____Y N DK

Sulfa Drugs _____Y N DK

Codeine or other narcotics _____Y N DK

Metals_____Y N DK

Latex (rubber)_____Y N DK

Iodine_____Y N DK

Food _____Y N DK

Other_____Y N DK

Do you have an artificial (prosthetic) heart valve?.....Y N DK

Any previous infective endocarditis? ……..…Y N DK

Do you have damaged heart valves in transplanted heart?.....Y N DK

Any Congenital Heart Disease (CHD)……..…… Y N DK

Unrepaired, cyanotic CHD?.....Y N DK

Repaired (completely) in the last 6 months? ……..….Y N DK

Repaired CHD with residual defects?.....Y N DK

Except for the conditions listed above, antibiotic prophylazxis is no longer recommended for any other form of CHD.

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Abnormal bleeding…… Y N DK
Specify:_____
AIDS or HIV infection …… Y N DK
Type of infection_____
Anemia…… Y N DK
Angina…… Y N DK
Arteriosclerosis…… Y N DK
Arthritis…… Y N DK
Asthma …… Y N DK
Autoimmune disease…… Y N DK
Blood transfusion…… Y N DK
Bronchitis…… Y N DK
Cancer/Chemotherapy
/Radiation Treatment …… Y N DK
Cardiovascular disease…… Y N DK
Chest Pain upon Exertion…… Y N DK
Chronic Pain …… Y N DK
Congestive heart failure…… Y N DK
Damaged heart valves…… Y N DK
Diabetes Type 1 or 2…… Y N DK
Specify:_____
Eating Disorder…… Y N DK
Epilepsy…… Y N DK
Excessive urination…… Y N DK
Fainting spells or seizures…… Y N DK
G.E. Reflux/ heartburn…… Y N DK
Gastrointestinal disease…… Y N DK
Glaucoma…… Y N DK
Heart attack…… Y N DK
Heart murmur…… Y N DK
Hemophilia…… Y N DK
High Blood Pressure…… Y N DK
Hepatitis…… Y N DK
Jaundice or liver disease…… Y N DK
Kidney problems…… Y N DK

Low blood pressure…… Y N DK
Malnutrition…… Y N DK
Mental health disorders…… Y N DK
Specify:_____
Mitral valve prolapsed…… Y N DK
Neurological disorder…… Y N DK
Night sweats…… Y N DK
Osteoporosis…… Y N DK
Other heart defects…… Y N DK
Pacemaker…… Y N DK
Persistent swollen glands…… Y N DK
Recurrent Infections…… Y N DK
Rheumatic fever…… Y N DK
Rheumatic heart disease…… Y N DK
Rheumatoid Arthritis…… Y N DK
Severe or rapid weight loss…… Y N DK
Sexually transmitted disease…… Y N DK
Sinus Trouble…… Y N DK
Sleep disorder…… Y N DK
Stroke…… Y N DK
Systematic Lupus Erythematosus… Y N DK
Thyroid problems…… Y N DK
Tuberculosis…… Y N DK
Ulcers…… Y N DK

Do you have any disease, condition, problem not listed above?.... Y N DK
Please Explain:
_____
_____
_____
_____

Please List ALL Medications (including those that are supplements or Over the Counter): _____

_____

_____

_____

I certify that I have read and understand that the above information given on this form is accurate. I understand the importance of an honest health history and that my dentist and her staff will rely on this information for treating me. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of error or omissions that I may have made in the completion of this form.

X_____

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Financial Policy

Our Practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of usual customary rates.

We accept cash, check, Visa, MasterCard, Discover and American Express as forms of payment.

Checks that are returned to our offices from your financial institution are subject to a $35 return check fee. This fee covers processing fees that are charged to our office.

For your convenience, this office may release your information to your insurance company, and receive payment directly from them.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept the assignment of benefits from your insurance company has not paid your account in full with 60 days, the balance will be transferred to your account.

Every effort will be made to help you with your insurance, but if they do not pay as expected in the case of claim denial from the insurance company or a service not covered by your specific insurance plan, you will still be responsible for the fee(s) charged.

If dentures, partial dentures, crown and bridge or any other work are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the prosthesis is cemented or inserted.

You will be responsible for a $25 or 10% rebilling fee (whichever is greater) on any balance 90 days past due.

There will be a fee of $25 for appointments broken without 48hours notice. All appointments made after 5pm; on Saturdays or are for more than 2hrs, the fee will be doubled.

Appointments with procedures totaling an amount higher than $500, 50% will need to be paid to confirm your reserved appointment. Any past due amounts will also need to be paid to reserve your appointment time.

Family or Group appointments are a courtesy that we give our patients. If the appointment block is missed or cancelled with less than 48hrs notice, this privilege will no longer be available

Treatment plans may change, and you will be responsible for the work actually done.

If sent to collections you will be responsible to pay all related fees.

The parent or guardian that accompanies the minor child/children to the appointment is responsible for any payment that is due.

We would be happy to discuss our charge and how they relate to your particular situation. We also realize that temporary financial situation may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Payment for services is due at the time services are rendered.

Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as a part of your treatment.

I have read the Financial Policy.
I understand and agree to this Financial Policy.

Signature of patient or responsible party:

_____ Date: _____

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I have been given the opportunity to review copy of this office's Notice of Privacy Practices. I may also request a hard copy of this notice for my records.

Print name: _____

Signature: _____

Date: _____

For office use only

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, acknowledgement could not be obtained because:

Communication Barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining the acknowledgement

Other please specify:

_____

_____

_____