New Patient Registration

DATE: ___/___/____

Zen Dental

NAME: _____ PREFERS TO BE CALLED: _____
FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

CELL PHONE: (___) ___-____ WORK PHONE: (___) ___-____ HOME PHONE: (___) ___-____

SSN: ____-___-_____ DOB: ___/___/_____ E-MAIL: _____ GENDER: F: ☐ M: ☐

EMERGENCY CONTACT: _____ PHONE: (___) ___-____

CHECK APPROPRIATE BOX: MINOR: ☐ SINGLE: ☐ MARRIED: ☐ WIDOW: ☐

Person Financially Responsible

NAME: _____ RELATIONSHIP:_____

OCCUPATION: _____ EMPLOYER: _____

CELL PHONE: (___) ___-____ WORK PHONE: (___) ___-____ HOME PHONE: (___) ___-____

SPOUSE NAME: _____ CELL PHONE: (___) ___-____

Medical History

Current Physician _____ PHONE: (_____) _____ - _____ Current medications _____

Check **Yes** or **No** to indicate if you have / had any of the following:

	YES	NO		YES	NO		YES	NO
Arthritis / Rheumatism	☐	☐	Heart Murmer	☐	☐	Sinus trouble	☐	☐
Artificial joints	☐	☐	Herpes	☐	☐	Seizures	☐	☐
Asthma or lung disease	☐	☐	Hepatitis _____	☐	☐	Stroke	☐	☐
AIDS / HIV	☐	☐	High blood pressure	☐	☐	Stomach Ulcers	☐	☐
Abnormal / excessive bleeding	☐	☐	Jaundice	☐	☐	Thyroid problems	☐	☐
Blood transfusion	☐	☐	Kidney problems	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Liver disease	☐	☐	Smoke / chew tobacco	☐	☐
Cortisone treatment	☐	☐	Low blood pressure	☐	☐	Tumores or cancer	☐	☐
Diabetes	☐	☐	Mitral valve prolapse	☐	☐	Venereal disease	☐	☐
Fainting	☐	☐	Pacemaker	☐	☐	(Women) Currently pregnant?	☐	☐
Glaucoma	☐	☐	Radiation treatment	☐	☐	Nursing?	☐	☐
Heart disease / problems	☐	☐	Rheumatic fever	☐	☐	Taking oral contraceptives?	☐	☐

Allergies? _____ Any other disease / condition not mentioned? _____

Dental History

Reason for your visit? _____ Date of last dental visit? _____

Previous dentist: _____ How often do you brush? _____ Floss? _____

Check **Yes** or **No** to indicate if you have / had any of the following:

	YES	NO		YES	NO		YES	NO
Bad breath	☐	☐	Clicking or popping of jaw	☐	☐	Periodontal treatment	☐	☐
Blisters / sores on lips / mouth	☐	☐	Head, neck, or jaw pain	☐	☐	Sensitivity to hot / cold / sweets	☐	☐
Chew on one side of mouth	☐	☐	Lip or cheek biting	☐	☐	Smoke / chew tobacco	☐	☐
Clench jaw or grind teeth	☐	☐	Loose teeth or broken fillings	☐	☐	Swollen / bleeding gums	☐	☐

Check any allergies you have: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other:_____

Patient Agreement

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide the proper care.

I agree to the use of anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf for my dependants, including any insurance benefits, submitted as a courtesy and at the discretion of this practice on my behalf, which are disputed, denied, or unpaid by my insurance company in 45 days from the date of service. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by an agreed upon date, I understand that a $10.00 per month late fee may be added to my account.

I further understand this office reserves the right to charge me a broken or missed appointment fee if notice is not given 48 hours in advance. Furthermore, I understand by signing this form I have read and understood this agreement in its entirety.

_____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY DATE

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.
PRINT NAME

_____ _____

SIGNATURE DATE

FOR OFFICE USE ONLY

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

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency prevented us from obtaining acknowledgement

☐ Other (Please Specify) _____

_____

_____

Zen Dental Office Policies

Welcome to our practice! We are pleased to have you as a patient and to be given the opportunity to be your partner in informed dental health care.

Referrals: The greatest compliment our patients can give us is the referral of their friend, loved ones and co-workers. We do not take the confidence you place in us lightly. We welcome new patients and promise to give them the same special attention and care you receive.

Telephone Calls: All patients are encouraged to call with any questions they have concerning dental procedures. Our staff is well-qualified to answer most questions. If a call requires the doctor to speak with you,the doctor will return your call at the earliest opportunity.

Emergencies: The office is closed on Friday - Sunday and Major Holidays. We reserve a limited amount of time each day to accommodate emergency patients so as not to infringe on the care of our scheduled patients. If you have a dental emergency please call our office as early in the day as possible. If you have an after-hours emergency, simply call the office at (404) 531-2003 and leave a message and someone will return your call.

Appointments: We try to see all patients on an appointment basis and ask that you please call in advance so we can reserve the appropriate treatment time for you. Because we respect the value of your time, we make every effort to be on time for our patients and ask that you please extend us the same courtesy.

Appointment Confirmations: Our office will make confirmation phone calls or send a text message to each scheduled patient two (2) days prior to their appointment. If we are unable to speak to you directly to confirm your appointment, please pay us the courtesy of returning our call to confirm your appointment.

Rescheduling Appointments: Even the most organized person will occasionally need to reschedule an appointment. When rescheduling is necessary, please provide our office a minimum of 48 hours notice. This courtesy makes it possible for us to offer your appointment time to patients in need of emergency or more timely care. Failure to extend this courtesy may result in a cancellation fee of $35.00 for the hygienist and $75 for an appointment with the doctor.

Diagnostic X-Rays: An oral evaluation warrants that we have recent diagnostic x-rays to detect decay, bone loss and hard tissue abnormalities on all patients. We will take a panoramic x-ray and bitewing x-rays or a full mouth series of x-rays on all New Patients to facilitate our initial evaluation. If you have a panoramic x-ray or full mouth series of x-rays that have been taken within the last three (3) years by another dentist, we will need you to request them from your previous dentist to save you the additional expense of taking new films. New films will be taken every three years. Panoramic x-rays will be taken every three years to evaluate bone health and bitewing x-rays will be taken annually to detect interproximal decay.

Cosmetic Services: One of our greatest joys is helping patients achieve the smile of their dreams! It is amazing to us how much even the simplest of cosmetic procedures can elevate a patient’s self-image and improve the quality of their life. Please feel free to express any interest you may have in enhancing your

smile. We will be happy to share our recommendations, discuss your treatment options, quote a fee and explain financing options without pressure.

Insurance: If you have insurance, we will be happy to file your insurance claim as a courtesy. However, you will be responsible for your deductible and coinsurance at each visit. Our computer software makes an estimate of what your insurance will cover and your “out of pocket” portion. This is only an estimate and final amounts may vary once the insurance has processed your claim. Any remaining balance will be your responsibility to pay.

Financial Policy: Thank you for choosing our office for your dental needs. At Zen Dental we make every effort to curb the cost of your dental care. You can assist us by both keeping your appointments and by paying at time of service to cut down on billing costs. Of course preventing problems before they develop is the simplest and most economical way to maintain good oral health. We realize that every person’s financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve which allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual’s medical and psychological health. To maintain practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial policies regarding their dental treatment. We offer several payment options: We accept payment by Cash, Debit or Credit Card. We accept MasterCard, Visa, American Express and Discover. Extended payments can often be arranged through Care Credit. All major treatment involving a laboratory procedure will require an appropriate down-payment. If your treatment plan requires several visits you will be given a written estimate of your financial obligation and asked to discuss and sign a definitive financial agreement with our financial coordinator.

Finance Charges: Finance charges, at a rate of 1.5% per month, will be assessed to any account that lapses 30 days without a personal payment. As witnessed by my signature, I hereby acknowledge I have been advised of the Office Policies of Zen Dental.

Patient Name: _____

Signature: _____ Date: _____