Patient Registration

Patient Information:

First name and middle initial: _____

Last Name: _____

Preferred name or nickname: _____

⬜ Male ⬜ Female ⬜ Other ⬜ Prefer not to answer

Pronouns: ⬜ She/Her ⬜ He/Him ⬜ They/Them

Date of birth: _____

Address: _____

City, State, Zip: _____

Best daytime phone number: (___)-_____-_____ Extension_____

Cell phone number: (___)-_____-_____ Home phone number: (___)-_____-_____

Email address: _____

Emergency contact name and number: _____ (___)-_____-_____

Relationship to patient: _____

Insurance:

Who is the insurance policy holder for this patient? _____

Social Security number for the policy holder: _____

Date of birth for the policy holder: _____

Responsible party (if other than the patient):

First name and middle initial: _____Last Name: _____

Address (if different from above): _____

City, State, Zip: _____

Cell phone number: (___)-_____-_____ Home phone number: (___)-_____-_____

Email address: _____

Financial/Cancellation Policy & Consent to Dental Treatment

We offer the following payment options:

- **Cash**
- **Check**
- **Visa, Mastercard, Discover, American Express**
- **LendingPoint (third-party financing)**

Your **dental benefits are determined by your employer and the amounts paid out sometimes vary** due to limitations, allowed fee schedules, used deductibles, and yearly maximums. We make every possible effort to generate an accurate estimate of this for you in advance, however, the insurance company and your employer make the final determination. **The benefits we investigate on your behalf are only estimates.**

All co-payments (patient portion) are the responsibility of the patient and are due at the time of your appointment/treatment. Any billed amounts denied by insurance are the patient's responsibility for payment.

Glō Dental Studio is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **We work hard to honor your appointments and hope that you will commit to do the same.**

Please call us by 2:00pm TWO DAYS prior to your scheduled appointment to notify us of any changes or cancellations. **To change a Monday appointment, please call our office by 2:00pm on Thursday.** This allows us enough time to ensure another patient can be offered that time in the schedule. **If advanced notice is not given, you will be charged up to $50 per hour for the appointment.**

If we are unable to reach you for confirmation, **your appointment may be removed from the schedule.** Your consideration in promptly replying via text confirmation, email or by returning a phone call is very important and much appreciated.

I understand the above information and have had the opportunity to ask questions. I hereby consent to be seen as a patient at Glō Dental Studio and agree to the recommended diagnostic procedures, including but not limited to radiographs, photographs, and a comprehensive examination.

Patient/Parent or Guardian *signature*: _____ Date: _____

Printed name of patient: _____

MEDICAL HISTORY

Patient Name: _____
Birth Date: _____
Today's Date: _____

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.

-Do you have a primary care doctor? Please list name and phone number:	YES NO	IF YES: _____
-Have you been hospitalized or had a major operation in the last 5 years?	YES NO	IF YES: _____
-Have you ever had a serious head and/or neck injury?	YES NO	IF YES: _____
-Have you ever taken medication for osteoporosis or cancer?	YES NO	IF YES: _____
-Are you on a special diet?	YES NO	IF YES: _____
-Do you use any form of tobacco?	YES NO	IF YES: _____
-Do you snore or stop breathing while sleeping?	YES NO	IF YES: _____
-Do you need Antibiotic Pre-Med before dental treatment?	YES NO	IF YES: _____
-Do you use controlled substances?	YES NO	IF YES: _____
-Do you experience frequent anxiety?	YES NO	IF YES: _____
-Are you taking any medications, pills, or drugs?	YES NO	IF YES: _____

Women Only: Are you…

☐ **Pregnant/Trying to get pregnant?** ☐ **Nursing?** ☐ **Taking oral contraceptives?**

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic

Do you have, or have you had, any of the following? If yes, please check all that may apply:

☐ AIDS/HIV+	☐ Low Blood Pressure	☐ Sickle Cell Disease	☐ Anaphylaxis
☐ Diabetes	☐ Thyroid Diseases	☐ Sinus Trouble	☐ Easily Winded
☐ Renal Dialysis	☐ Chest Pains	☐ Leukemia	☐ High Blood Pressure
☐ Angina	☐ Cold Sores/Fever Blisters	☐ Liver Disease	☐ Artificial Heart Valve
☐ Epilepsy or Seizures	☐ Congenital Heart Disorder	☐ Swelling of Limbs	☐ Artificial Joint
☐ Hives or Rash	☐ Heart Trouble/Disease	☐ Chemotherapy	☐ Asthma
☐ Hypoglycemia	☐ Hemophilia	☐ Heart Attack/Failure	☐ Blood Disease
☐ Irregular Heartbeat	☐ Recent Weight Loss	☐ Heart Murmur	☐ Convulsions
☐ Blood Transfusion	☐ Anemia	☐ Heart Pacemaker	☐ Stroke
☐ Frequent Headaches	☐ Emphysema/COPD	☐ Psychiatric Care	☐ Cancer
☐ High Cholesterol	☐ Shingles	☐ Radiation Treatments	☐ Mitral Valve Prolapse
☐ Alzheimers	☐ Hepatitis B or C	☐ Herpes	☐ Arthritis/Gout
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting Spells/Dizziness	☐ Kidney Problems
☐ Breathing Problems	☐ Bruise Easily	☐ Glaucoma	☐ Tonsillitis
☐ Tuberculosis	☐ Tumor or Growths	☐ Stomach/Intestinal Disease	☐ HPv

Have you had any serious illness not listed? If yes, please explain:

_____
_____
_____

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: _____

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE HIPAA PRIVACY PRACTICES ACT CONSENT & AUTHORIZATION FORM FOR RELEASE OF PERSONAL INFORMATION

Patient name (print): _____ Date: _____

The undersigned acknowledges the offer to receive a copy of this healthcare facility's Notice of Privacy Practices. A copy of this document shall be as effective as the original and is available by request.

_____ _____

Patient/Parent/Guardian or Legal Rep ***Signature*** Printed name of person who signed

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, DISCUSS TREATMENT, HEALTH and/or BILLING INFORMATION VIA:

__Home Phone __Work Phone __Cell Phone
__Email __Text Message __All/Any of these contact points

MY SIGNATURE WILL ALSO SERVE AS RECORD RELEASE AS NEEDED