Welcome!

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ **Social Security Number**:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Dental Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

-- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Dr. Andrew J Dietz DDS

[patient.nextapptprovider], [patient.nextapptdate], [patient.nextappttime]

MEDICAL DENTAL HISTORY FORM

Patient Name:
Patient ID #:

Medical Clinic_____

Physician_____

Allergies to:
Latex: Yes No
Medications _____
Other _____

PreMed required? Yes No

Reason: _____

Type: _____ Dosage: _____

Current Medications (Prescription, Over the counter and Herbal)

	MEDICATION		DOSAGE		FREQUENCY			MEDICATION		DOSAGE		FREQUENCY	

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes		Yes
8 Under physician's care?		34 Asthma?	
Details:		35 Sleep Apnea?	
9 Hospitalization/operation(s) in last 5 years?		36 Tuberculosis?	
Details:		37 Sinus trouble?	
10 Head/neck/mouth injuries?		38 Cancer?	
11 Women: pregnant?		39 Radiation Treatment to Head/Neck?	
12 Women: nursing?		40 Chemotherapy?	
13 Women: oral contraceptives?		41 Kidney Disease?	
14 Heart trouble/disease?		42 Dialysis?	
15 Rheumatic fever?		43 Eating Disorder?	
16 Past use of Fenphen?		44 Stomach: reflux? ulcer?	
17 Heart murmur?		45 Immunological disease?	
18 Mitral valve prolapse?		46 Sjogrens Disease?	
19 Heart surgery?		47 Fibromylagia?	
20 Artificial heart valves?		48 Other autoimmune disease (lupus, pemphilus)?	
21 Pacemaker?		49 Arthritis or other joint disorders?	
22 Indwelling defibrillator?		50 Diabetes? Type: Controlled? Y N	
23 Artificial joints?		51 Headaches?	
24 History of Organ Transplant?		52 Depression: Diagnosed?	
25 High blood pressure? BP: /		53 Other Psychiatric Disorders?	
26 Stroke?		54 Neurologic Disease?	
27 Bleeding problem?		55 Convulsions?	
28 Hemophilia?		56 Epilepsy/seizures?	
29 Anemia?		57 Cerebral Palsy?	
30 Leukemia?		58 Fainting/dizziness?	
31 Lung disease?		59 Venereal disease?	
32 Emphysema?		60 AIDS/HIV positive?	
33 Shortness of Breath?		61 Alcohol or chemical dependency?	
		62 Hepatitis?	
		63 Thyroid disease?	
		64 Glaucoma?	

TOBACCO

	Yes
65 Tobacco user?	
Type:	
Amount:	
Number of years:	
66 How soon after wake up do you use tobacco? <30 minutes >30 minutes	
67 Previous attempts to quit?	
Number of attempts:	
Longer period of success:	
Methods used:	
68 Are you interested in quitting tobacco?	
69 Former tobacco user?	
Type:	
Amount:	
Year quit:	

DENTAL INFORMATION:

70 Previous dentist:	
71 Last dental visit:	
72 Last dental cleaning:	
73 Frequency of dental exams:	
74 What made you decide to make this dentist appointment?	
75 Frequency of brushing:	
76 Frequency of flossing:	
77 What are some typical foods you eat between meals?	
78 What types of beverages do you typically drink between meals?	
79 How often do you chew or suck on hard candy, cough drops or mints?	
80 Do you use fluoridated toothpaste?	Yes
81 Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water	

PAST DENTAL TREATMENT:

	Yes
82 One or more fillings in the last three years?	
83 Family history of extensive decay?	
84 If Child, mother's history of decay?	
85 Treatment for periodontal (gum) disease?	
86 Family history of periodontal disease?	
87 Have you had orthodontics (braces)?	
88 Have you had oral surgery?	
89 Have you had any dental implants placed?	
90 Treatment for tempormandibular disorders?	
91 Do you wear a denture(s) or partial denture(s)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH:

92 Dry mouth/excessive thirst?	
93 Sensitive teeth? Hot Cold Pressure Sweets	
94 Mouth odors/bad taste?	
95 Cold sores/blisters/oral lesions?	
96 Are you aware of any swelling or lumps?	
97 Sore, bleeding gums?	
98 Loose teeth?	
99 Difficulty chewing?	
100 Food catches between teeth?	
101 Teeth/filling break frequently?	
102 Clenching or grinding habits?	
103 Do you hear popping, clicking or snapping?	
104 Do you have jaw pain?	
105 Are you nervous about dental work?	

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INSURANCE AUTHORIZATION: SIGNATURE ON FILE

By signing this form, I hereby authorize my dental care provider to release all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all dental benefits due to me and my dependents.

I also authorize payment of dental insurance benefits otherwise payable to me, directly to my dentist as listed above.

I understand that any insurance estimate given to me by my dental office is not a guarantee of payment and I am responsible for all charges and services not paid by my insurance company.

_____ _____

Signature of Responsible Party **Date**

The signature on File (SOF) is valid from this date. A photocopy of this authorization may act as an original.

Consent for Services and office polices

We take great pride in the dentistry we perform here. Our dentistry is guaranteed; under the condition that our patients make a firm **commitment** to maintain their dental health with office Re-Care visits every six months. This is essential to track the progression of your dental health.

Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being – we are. We will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.

As a condition of your treatment by this office, financial arrangements are made prior to treatment and payment is due at the time services are rendered. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies. All emergency dental services, or any dental services performed without financial arrangements, must be paid by cash, check, or credit card, at the time services are rendered.

Our office accepts assignment of benefits from the insurance company as a courtesy for our patients with the full understanding that all co-pays and deductibles are due at the time of service. Insurance estimates are not a guarantee of payment, and any remaining balance due after the insurance company has paid their portion is the sole responsibility of the patient. Our office cannot render services on the assumption that our charges will be paid by an insurance company.

Appointments are **confirmed usually 2 days in advance**. We will attempt to reach you in person to confirm your scheduled appointment. It is greatly appreciated when you have an appointment scheduled that you **call our office to confirm your appointment** in the event we were unable to reach you.

No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 2 business days of your appointment to reschedule. There is a $50.00 fee for all no-show appointments and this fee is not covered by insurance.

I have read the above conditions of treatment and payment, and agree to their content.

_____Date:_____ Relationship to patient:_____

(Signature of Patient or Guardian)

Andrew J. Dietz, D.D.S., P.A.

Prosthodontist

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Haddon Heights, NJ 08035
Telephone (856) 547-8664

FINANCIAL AGREEMENT

Dear Patient/Parent:

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstandings can be avoided**.**

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid by the insurance company. With or without insurance coverage, you are responsible for full payment of your total bill.

Payment is due and payable as services are rendered.

For your convenience, our office has made arrangements with Care Credit and now able to offer low monthly payments to our valued patients.

Please indicate the way you wish us to handle your account:

1. ____ I will pay check, cash, Visa, MasterCard or apply for Care Credit.
2. ____ I have insurance and will pay my portion the day of treatment.
3. ____ I have no dental insurance and would like to discuss my options with the financial coordinator.

Extensive Treatments, (eg. Crowns, root canal, dentures, cosmetic dentistry) require 1/3 deposit on first day of treatment. Also balance must be paid before final insert.

Missed appointments-No charge will be made for rescheduling an appointment provided 2 business days notice is given. OTHERWISE THERE IS A CHARGE OF $50.00.

RETURNED CHECKS - THERE WILL BE A $30.00 HANDLING CHARGE IN ADDITION TO ANY BANK CHARGES FOR RETURNED CHECKS.

IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS.

_____ _____

Patient/Parent signature Date