Welcome to Tobler Dental!

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______________________________________ Would you like to receive our e-newsletter? ☐ Yes ☐ No

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 **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:___________________________

Dental History

Please check the following problems that apply:

- Sensitivity (hot, cold, sweet) ☐
- Headaches, earaches, neck pain ☐
- Jaw joint pain ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad breath ☐

Do you have or have you had any of the following:

- Dentures ☐
- Partial dentures ☐
- Braces ☐
- Periodontal (gum) treatments ☐

Please share the following dates:

- Your last cleaning ___________
- Your last oral cancer screening ___________
- Your last complete x-rays ___________

Name of previous dentist:

City_______________ State _______________

Phone number _________________________

What is the most important thing to you about your smile and overall dental health?__________

____

If you could whiten your teeth for a cost you could afford, would you do it? ☐

Do you smoke or use tobacco? ☐

How long?_________ How much? _________

If you could change your smile, you would?

- Make them whiter ☐
- Make them straighter ☐
- Close spaces ☐
- Replace silver colored fillings with tooth colored restorations ☐
- Repair chipped teeth ☐
- Replace missing teeth ☐
- Replace old crowns that don't match ☐
- Have a smile makeover ☐

On a scale of 1-10, with 10 being the highest rating:

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

- Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

- Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Medical History

Please check the following that apply:

☐ AIDS
☐ Allergies (seasonal)
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart conditions
☐ Heart Lesions (congenital)
☐ Heart murmur
☐ Heart Surgery
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Jaw Joint Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Phen Fen (1 month+)
☐ Pregnant Currently
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic fever
☐ Rheumatism
☐ Scarlet fever
☐ Seizures
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Diseases
☐ Other__________

____

Do you have any of the following drug allergies?

☐ Aspirin
☐ Darvon
☐ Nitrous Oxide
☐ Percodan
☐ Local Anesthetic
☐ Tetracycline
☐ Codeine
☐ Erythromycin
☐ Valium
☐ Penicillin
☐ Sulfa
☐ Other

Are you under a physician's care? What for?__________________

____

Are you taking any medication? What?________________

____

Family Physician__________________**Phone#**__________

Patient Signature (Parent of Child) ____________________ Date:__________ Dentist Signature__________________

Tobler Dental

Appointments Policy

We understand that your time is valuable. You can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time as we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you are unable to make your appointment, please provide us at least 24 hours advanced notification. Short cancellations (less than 24 hours) or missed appointments are subject to a $50.00 cancellation fee. Patients who habitually miss or cancel appointments may be dismissed from the practice.

We make every effort to keep precisely to our daily schedule but we will adjust the schedule when a patient arrives in pain or when a treatment takes more time than expected. We appreciate your understanding and cooperation. If circumstances require dramatic changes to the schedule, we will do our best to notify you as far in advance as possible.

Financial Policy

Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. Unless another financial option is pre-arranged, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Tobler Dental, the estimated patient portion will be the amount due, and any applicable deductibles will also be collected. Insurance payments without assignment will be sent to the insured with payment due in full on the date of service.

We must emphasize that as dental care providers our relationship is with you, not your insurance company. While the filing of insurance claims and checking on your benefits is a service that we extend to our patients, all charges are your responsibility from the date services are rendered. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. You are responsible for any payment discrepancy that your insurance company may fail to pay due to the terms of your contract with them. If payment is not received within 30 days of the statement date, a late charge of 2.5% will be added to the account balance each month.

We accept most major credit cards, cash, and check for payment. We also offer CareCredit.

Authorization and Consent

General Consent to Treatment

I agree and consent to dental examinations by licensed dental professionals at Tobler Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to such treatment being rendered. All treatment will be rendered by qualified dental personnel in accordance with governing healthcare laws. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Tobler Dental to release any information regarding my dental/medical history, diagnosis or treatment to third-party payors and/or other health professionals as required.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Tobler Dental.

Office Policies

I acknowledge and agree to the Appointments Policy and Financial Policy. I hereby acknowledge the receipt of a copy of the practice's HIPAA Privacy Policies and Procedures. I understand I may ask any questions regarding these policies.

______________________________ *Signature of Patient, Parent, or Guardian*

______________ *Date*

______________________________ *Please Print Name of Patient, Parent, or Guardian*

______________ *Relationship to Patient*