*Aquidneck Dental, Inc.  21 King Charles Drive  Portsmouth, RI 02871  401.683.5990*

# Patient Registration

## Please complete each question, signature required at X's

**Patient Information** Date___/___/___

**Patient's Name**_____
Last First Middle Preferred

**Address**_____
Street City State Zip

**Home Phone #**_(___)_____ **Cell #**(___)_____ OK to receive Text?___ **Email**_____

**Date of Birth**___/___/___ **Social Security #**_____ **OR Drivers Lic #**_____ **State**____

*If patient is a minor, Parents' or Guardians' name_____

**Employer**_____ **Work Phone #**__(___)_____ **Ext.**_____

**May we call you at work?** ☐ **Yes** ☐ **No** **Best time to call**_____ **Best Tel # to call**_____

***Who may we thank for referring you to our office?***_____

**Responsible Party Information**

**Name of Person Financially Responsible for Account**_____
Last First Middle

Responsible Party's Address_____
Street City State Zip

Responsible Party's Home Phone #___(___)_____ Work Phone #___(___)_____

Responsible Party's Social Security #_____ Date of Birth___/___/___ Relation to Patient_____

Responsible Party's Employer_____

**Insurance Information**

**Name of Insurance Cardholder**_____ **Cardholder's Date of Birth**__/___/____

Dental Insurance Co._____ Insurance Cardholder's Employer_____ Insured's ID #_____

*Do you have more than 1 dental insurance coverage? ☐ Yes ☐ No (If yes, please complete below)

Name of Secondary Insurance Cardholder _____

Dental Insurance Co._____ Insurance Cardholder's Employer_____ Insured's ID #_____

**Consent to Release of Information to Insurance Co. /Consent to Assignment of Benefits**

X **Signature** (Parent's signature if patient is a minor)_____

**Consent to Aquidneck Dental Associate's Financial & Appointment Policy**

In an effort to hold down fees, payment is required at the time of service. If you have dental insurance, we will estimate your dental benefit and require payment of deductibles and estimated patient portion when treatment is rendered. Please remember that we try to help you understand and to maximize your insurance benefits, but dental insurance is a contract between the patient, the employer and the insurance company. Ultimately, the patient is financially responsible for all treatment rendered.

**As a courtesy, Aquidneck Dental Associates requires 48 hours notice for any appointment change or cancellation to avoid an office visit fee.**

X **Signature** (Parent's signature if patient is a minor)_____

Revised 02/01/11mc

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**Patient Medical History**

Physician's Name_____ Date of last Medical Check Up___/__/__

Physician's Address_____ Physician's Phone #_(___)_____

1. Are you under medical treatment now? ☐ Yes ☐ No
   If yes, for what?_____
2. Do you currently have any medications prescribed for you? ☐ Yes ☐ No
   If yes, please list all medications, vitamins and supplements_____
   _____
3. Have you ever had any major operations? ☐ Yes ☐ No
   If yes, what_____ When?_____
4. Have you had any wounds that healed slowly? ☐ Yes ☐ No
5. Have you had any adverse reactions to any medications, foods, or materials? ☐ Yes ☐ No
   If yes, please list all items_____
6. Are you currently in good health? ☐ Yes ☐ No
7. For Women: Are you, or is there a possibility you may currently be pregnant? ☐ Yes ☐ No
8. Are you currently taking any medications to treat Osteoporosis? ☐ Yes How long?_____ ☐ No
9. Do you use any tobacco products? ☐ Yes ☐ No

**Has your physician ever informed you that you have or had:**

| | | | |
|---|---|---|---|
| Allergies/Hay Fever | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Latex Allergy | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Metal Allergies | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Mental Disorders | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Nervous Disorders | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No |
| Cancer/Tumors | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No |
| Clotting Disorder | ☐ Yes ☐ No | Pregnancy | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No |
| Dizziness/Fainting | ☐ Yes ☐ No | Respiratory Problems | ☐ Yes ☐ No |
| Epilepsy/Seizures | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Excessive Bleeding | ☐ Yes ☐ No | Sinus Problems | ☐ Yes ☐ No |
| Glaucoma | ☐ Yes ☐ No | Stomach Problems | ☐ Yes ☐ No |
| Head Injuries | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Heart Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Heart Surgery | ☐ Yes ☐ No | TMD | ☐ Yes ☐ No |
| High/Low Blood Pressure | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Heart Murmur/ MVP | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Hepatitis | ☐ Yes ☐ No | Other *** | ☐ Yes ☐ No |
| HIV/AIDS | ☐ Yes ☐ No | ***Please list_____ | |
| Jaundice/Liver Disease | ☐ Yes ☐ No | _____ | |

**Dental History**

**What is your main dental concern?**_____

When was your last Dental Exam?_____ Last X-rays?_____ Last Cleaning?_____

Have you had Orthodontic Treatment? ☐ Yes ☐ No
Have you had Periodontal Treatment? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No.....Daytime?____Nighttime?_____
Do you have ear pain, sore muscles? ☐ Yes ☐ No.....Do you awaken with headaches?_____
Are you apprehensive about seeing a dentist? ☐ Yes ☐ No.....Why?_____

**Emergency Information**

Name of nearest relative not living with you_____ Phone#_(___)_____

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# FINANCIAL POLICY

Thank you for choosing Aquidneck Dental, Inc. as your dental health care provider. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered. For your convenience, Aquidneck Dental, Inc. accepts cash, checks, MasterCard and VISA. 6 month interest free payment plans are available through CareCredit for qualifying patients and must be arranged prior to treatment.

## PATIENTS WITH DENTAL INSURANCE

Dental Insurance often does not usually cover the total cost of your treatment. Based on your individual plan, we usually can ***estimate*** the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. Most insurance companies will respond within four to six weeks, Please call our office if your statement does not reflect your insurance payment within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated. If your insurance company fails to pay within 60 days of your claim, you will be responsible for the full fee.

**Aquidneck Dental, Inc. requires 48 hours notice for any appointment change or cancellation to avoid an office visit fee. In an effort to hold down costs, Aquidneck Dental, Inc. no longer sends monthly statements. Any balance owed after insurance has processed claims will be due upon receipt. Payment that is not made within 30 days will accrue interest at a monthly rate of 1.0% or 12% annually.**
**Thank you.**

## ACCEPTANCE AGREEMENT

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for **ALL** fees, regardless of insurance coverage.

**Patient/Responsible Party:** _____
**PLEASE PRINT NAME**

**X**_____
**PLEASE SIGN**

_____
**DATE**

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