PATIENT REGISTRATION

Name: _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip Code: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Marital Status: _____

Occupation: _____Employer:_____

Parent's Name (if patient is a minor): _____

Name and Phone Number of Emergency Contact: _____

Whom may we thank for referring you to our office? _____

Name, address and phone number of nearest relative not living with you:_____

_____

Relationship to Patient:_____

Email: _____

FINANCIAL INFORMATION

Name of person financially responsible for this patient: _____

Address: _____ City: _____State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____ Social Security #:_____

Employer Name and Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____Group or Contract No:_____

Address: _____Phone Number:_____

Insured's Name:_____ Insured's Date of Birth: _____

Insured's Social Security No:_____ Insured's Employer:_____

Secondary Insurance Carrier:_____ Group or Contact No:_____

Address: _____ Phone Number: _____

Insured's Name;_____ Insured's Date of Birth: _____

Insured's Social Security No: _____ Insured's Employer: _____

Please note that our office policy requires payment at the time services are provided.

Regardless of any anticipated insurance benefits, I understand that I am fully responsible for the payment of any balance on this account:

Signature: _____ Date: _____

HEALTH HISTORY

Patient Name: _____ How do you wish to be addressed: _____
General Information (For our records only and will be kept confidential):

Physician name: _____ Date of last physical exam: _____

Name of previous dentist:_____ Date of last dental exam:_____

Date and type of last dental x-rays (if known):_____
CIRCLE:

YES NO 1. Are you having pain or discomfort at this time? _____
YES NO 2. Do you feel nervous about having dental treatment?_____
YES NO 3. Have you ever had a bad experience in a dental office? _____
YES NO 4. Have you been a patient in the hospital during the last two years? _____
YES NO 5. Have you been under the care of a medical doctor during the last two years? _____
YES NO 6. Have you taken any medicines or drugs in the last two years? If yes, which ones? _____
_____
YES NO 7. Are you taking any vitamins, herbal supplements, or "cures"? _____
YES NO 8. Are you allergic to (i.e. hives, rash, itching, difficulty breathing) any medicines? If so, which ones? ___
_____
YES NO 9. Are you intolerant to any medicines (upset stomach, ringing in ears, nausea, vomiting?) If so, which ones?
_____
YES NO 10. WOMEN: Are you pregnant? _____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH APPLY TO YOUR PRESENT OR PAST HEALTH

Heart Failure	Ulcers	Alcoholism	Herpes
Heart Disease or Failure	Mental Retardation	Cortisone Medicine	Seizures/Epilepsy
Angina Pectoris	Emphysema	Glaucoma	Fainting or Dizzy
High Blood Pressure	Cough (>10 days)	Pain in Jaw Joints	Any Type of Implant**
Heart Murmur**	Tuberculosis (TB)	Birth Defects	(heart valve, knee, joint, etc)
Rheumatic Fever	Asthma	HIV Positive, ARC, AIDS	Psychiatric Treatment
Congenital Heart Lesions	Hay Fever	Hepatitis A	Sickle Cell Disease
Use of Tobacco Products	Sinus Trouble	Hepatitis B	Bruise Easily
Thyroid Disease	Allergies or Hives	Hepatitis C	Liver Disease
Heart Pacemaker/ICD	Diabetes	Jaundice	Artificial Hip/Knee
Or other			
Sexually Transmitted Disease	Heart Surgery	Blood Transfusion	Drug Addiction
Cancer (type) _____	Radiation Therapy	Hemophilia	Anemia
Chemotherapy	Any Type of Transplant**	Kidney Trouble	Arthritis
Cold Sores	Any other condition not listed: _____		

**for these conditions only, is antibiotic pre-medication required prior to your dental appointment? _____

CIRCLE

YES NO 11. Have you ever had oral hygiene instructions (brushing/flossing your teeth)? _____
YES NO 12. Are there any growths or sores in or around your mouth? _____
YES NO 13. Do you have any trouble chewing? _____
YES NO 14. Does food catch between your teeth? _____
YES NO 15. Do you have pain in or near your ears? _____
YES NO 16. Do you habitually clench or grind your teeth during the day or night? _____
YES NO 17. Have you ever been told that you have "gum problems"? _____
YES NO 18. Do you now have bleeding gums or any other gum condition? _____
YES NO 19. Is there anything you dislike about your smile? _____

Signature: _____ Date: _____

FOREST HILLS FAMILY DENTISTRY

Dr. Franklin D. Wright, D.M.D.
Dr. Bradley A. Dorsch, D.D.S.

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.

_____
Please Print Name

_____
Signature

_____
Date

Please list the name(s) of the person(s) we can share your information with:

_____

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 the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify)

_____

_____

_____

_____

FRANKLIN D. WRIGHT, DMD
BRADLEY A DORSCH, DDS
WWW.CINCYTOOTHDOC.COM
PHONE: (513) 231-5353

FINANCIAL POLICY

In an effort to assist patients in affording their dental care while providing the highest level of professional care, we have established a number of payment options for our patients. Our practice philosophy is one of patient- centered care, not insurance directed care. It is most important to us that we correctly diagnose your oral health issues and recommend the most appropriate treatment at the highest level of care to each of our patients, not at some arbitrary level of care dictated by a third party.

For patients who are without dental insurance we offer a unique patient loyalty program at an affordable monthly rate. We are happy to assist you in joining our patient loyalty program at the time of your visit or you can visit our website www.cincytoothdoc.com for more information and to sign up from the comfort of your own home. A pamphlet explaining our loyalty program is also enclosed for your review.

We are contracted with some dental insurance companies and we are happy to submit claims on your behalf. It is important to remember however that ultimately dental insurance is a contract between you, your employer, and the insurance company. It is imperative that current insurance information be provided at each visit to avoid charges associated with needing to refile claims. We do not have any input into what procedures are covered by your insurance plan. It is the responsibility of the insured to know their dental insurance benefits, but we are happy to assist you in coordinating benefits to maximize your out of pocket expenses.

We will submit claims to your dental insurance, however the patient's estimated co-payment is due at the time services are provided. We understand that in more complex cosmetic and restorative cases that financial considerations can play a role in treatment decisions. We are pleased to offer several payment options in these cases. Our office can assist you in applying for interest-free financing with Care Credit, a company that finances exclusively medical and dental expenses not covered by insurance. We also accept Visa, MasterCard, and American Express, Discover, cash and check.

Our website has all the details about our financial policies. We encourage you to visit us at www.cincytoothdoc.com to see all that we have to offer. Please don't hesitate to call or contact us with any questions you may have. We look forward to taking great care of you.