POSITIVE IMAGE DENTAL REGISTRATION FORM

Name:

Last_____First_____MI____ Title_____

*Preferred Name:_____

Female___ Male___

DOB: DAY: _____ MONTH : _____ YEAR: _____

Address:_____ Parish:_____ Postal Code:_____

Mailing Address:_____

Home Phone:_____Work:_____ Cell Phone:_____

Preferred Contact #:_____

E-mail Address:_____

Name of Present Employer:_____ Occupation:_____

If Student, Name of School:_____ Grade:_____

Length of Employment:_____

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via **EMail** or **Phone**? (Please circle preference)

INSURANCE INFO:

Subscriber Name:_____Relationship to Patient:_____Subscriber DOB:__/__/__

Subscriber Employer:_____

Insurance Company Name:_____

Group Number:_____ Certificate Number:_____

■ **Assignment and Release** ■ I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Positive Image Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please be advised that we are a member of the Bermuda Credit Association, a balance not paid in 4 months after the last treatment will be forwarded to collections unless a previous agreement is in place and the patient will be responsible for the collection fee as well as the total balance. Notification for cancellation of appointments 48 working hours in advance is required otherwise a fee will be applied.

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Responsible Party Signature:_____ Relationship:_____
Date:_____

Patient/Guardian: Print:_____ Signature:_____

Medical History

Patients Name:

Physician's Name:_____ Physician's Phone:_____ Date of last appt:____/____/____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No Please list each one:

Have you ever had any surgical procedures? ❑ Yes ❑ No Please list each one:

Emergency Contact: Name:_____ Relationship:_____

Phone:_____

Conditions: Check if YES	**Conditions**	**Conditions**
❑ Abnormal Bleeding	❑ Glaucoma	❑ Stroke
❑ Alcohol Abuse	❑ HIV+ AIDS	❑ Thyroid Problems
❑ Allergies	❑ Heart Attack	❑ Tuberculosis
❑ Anemia	❑ Heart Murmur	❑ Ulcers
❑ Angina Pectoris	❑ Heart Surgery	❑ Sickle Cell Disease
❑ Arthritis	❑ Hemophilia	**Allergies**
❑ Artificial Heart Valve	❑ Hepatitis A	❑ Aspirin
❑ Asthma	❑ Hepatitis B	❑ Codeine
❑ Blood Transfusion	❑ Hepatitis C	❑ Dental Anesthetics
❑ Cancer	❑ High Blood Pressure	❑ Erythromycin
❑ Chemotherapy	❑ Joint Replacement	❑ Jewelry
❑ Colitis	❑ Kidney Problems	❑ **Latex**
❑ Congenital Heart Defect	❑ Liver Disease	❑ Metals
❑ Diabetes	❑ Low Blood Pressure	❑ Penicillin
❑ Difficulty Breathing	❑ Mitral Valve Prolapse	❑ Tetracycline
❑ Drug Abuse	❑ Pacemaker	❑ Other: Please list:
❑ Emphysema	❑ Psychiatric Problems	
❑ Epilepsy	❑ Behavioral Problems	**If Female, Please Answer**
❑ Facial Surgery	❑ Radiation Therapy	❑ Are you taking Birth Control Pills?
❑ Fainting Spells	❑ Rheumatic Fever	
❑ Fever Blisters	❑ Seizures	❑ Are you pregnant?
❑ Frequent Headaches	❑ Sexually Transmitted Disease	If so, # of Weeks _____
❑ Sinus Problems	❑ Shingles	❑ Are you nursing?

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

Dental History

How may we help you today?

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you been instructed to take antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Are you under stress? (new job,moving,relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No If no, please explain :

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Do you have any difficulty sleeping? ❑ Yes ❑ No

Do you notice yourself snoring or has your spouse or partner mentioned it? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? When was your last dental visit?

Why did you leave your previous dentist? How can we accommodate you better during your dental visit?

Here at Positive Image Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Whitening	Crowns	Invisalign	Implants
Bonding	Sealants	Bridge	Veneers

Information on my behalf:_____

I _____ hereby give Positive Image Dental permission to give_____ information on my behalf.

I _____hereby give Positive Image Dental permission to give_____ information on my financial balance on my behalf.

By signing the above information I am aware that the above named person(s) will be able to contact the office at any time and receive this information. I am also aware that I can contact the office at any time to change this.

Confidentiality

I understand that as I am over the age of 18 I have the right to confidentiality. Therefore my records and information regarding me as a patient will now only be available to myself unless I have given signed permission to Positive Image Dental that states otherwise.

Patient Rights and Responsibilities

Positive Image Dental

The many basic rights of dental patients include:

- to receive oral health care in a healthy and safe environment, and with compassion and respect for their rights and dignity;
- access to competent, high-quality, fair and ethical oral health information and care;
- protection of their personal privacy;
- necessary concern for their needs, best interests, reasonable preferences, and complaints; and
- encouragement to participate in decision-making processes affecting their oral health care.

Such basic patients' rights must be balanced by their responsibilities to help safe, quality, efficient and ethical oral care to be provided for all members of society, and to acknowledge their responsibility for safeguarding their own oral health. These responsibilities arise their general ethical obligations and public responsibilities and include their obligation to:

- show respect for the well-being and needs of others;
- understand that dentists desire to be reasonably effective and equitable in providing appropriate care to all members of the community;
- give the necessary priority to oral health and accept their responsibility for their own oral health;
- acknowledge the reality and limits of individual oral health care;
- understand the variance in how oral health care can be legitimately delivered; and
- know their rights as patients and the limitations of these rights.

Positive Image Dental Financial Agreement

- ❏ Payment is due at the time of service
- ❏ Procedures taking more than 1 visit, (ie crowns, bridges and dentures) half the patient total is due at the first visit and the balance before completion
- ❏ Accounts over 30 days overdue are subject to a 1.5% per month interest charge.
- ❏ Treatments over 2000$ may be eligible for extended payment plan at 9% per annum if arranged prior to the treatment.
- ❏ We will submit predeterminations to your insurance for any major work and will take payment directly from your insurer. Should the insurance company not pay for any reason, you will be responsible for the charge.

Missed appointment Agreement

- ❏ A fee will be applied if an appointment is missed or canceled within 48 business hours of the appointment.
- ❏ At the third offense, an appointment can only be made if the patient pre-pays for the appointment at the time of scheduling.

Collections Agreement

- ❏ Positive Image Dental is a member of the Bermuda Credit Association, a balance not paid in 4 months after the treatment completion will be forwarded to collections. An additional BCA processing fee will be added to the outstanding bill.

By signing below, I acknowledge that I have read, understand, and agree to abide by the provisions set forth:

*Patient Name:*_____.
Patient Signature: _____ *Date:*_____
Office Signature: _____