Practice Policies

Patient Name: _____ Date:_____
First Last M mm/dd/yyyy

Same Day Cancellation Policy

- Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office. We ask that you make every effort to give us at least a 24-hour notice if you cannot make your scheduled appointment. It is our policy to charge any patient a cancellation fee of 20% of the scheduled treatment for a broken appointment that was not given a 24 hour notice. Thank you for understanding the value of our cancellation policy to each of our patients.

Payment Policy

- Our practice policy is that payment is due at the time of treatment. If you are covered by a dental insurance plan, we will gladly file your insurance forms for you with a request to have the benefits assigned to the office. If you are responsible for a co-payment, we require that this be paid when treatment begins.

Notice Of Privacy Practices

- Please see attached form titled “Notice Of Privacy Practices For Protected Health Information”.

I have read and acknowledge that I understand in full the cancellation and payment policy of Pearl Dental

_____
Patient Signature

I have read and acknowledge that I understand in full the Notice Of Privacy Practices

_____
Patient Signature

Patient Registration

Patient name: _____ Preferred name: _____ Date: _____
LAST FIRST M

Patient email: _____ May we email you appt reminders, post-appt emails, etc? ☐Y ☐N

Cell phone: _____ Home phone: _____

Preferred appointment reminder method *(circle all that apply)*: ☐ Call cell ☐ Text Message ☐ Email ☐ Call home

Mailing address: _____
STREET APT # CITY STATE ZIP

Date of birth: _____ Patient gender *(circle)*: ☐ Female ☐ Male ☐ Other: _____
MONTH DAY YEAR

Preferred language: _____ Social Security #: _____

Who may we thank for referring you? _____

Emergency contact name: _____ Emergency contact phone: _____

Is patient a student *(circle one)*: ☐ N/A ☐ Full-time ☐ Part-time Name of school: _____

Patient employment status *(circle one):* ☐ N/A ☐ Full-time ☐ Part-time Employer: _____

Patient marital status *(circle one)*: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Child ☐ Other

Other family members seen here: _____

Person responsible for account *(circle one)*: ☐ Patient/Self ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

Dental Insurance Information

Does the patient/parent have dental insurance? *(circle one)* ☐ Yes ☐ No If YES, please complete this section:

Primary dental insurance (e.g. your insurance), if applicable:

Subscriber's name: _____ Employer, occupation:_____
LAST FIRST M

Subscriber's date of birth: _____ Subscriber's social security #: _____
MONTH DAY YEAR

Insurance company: _____ Insurance company phone #: _____

Insurance company address: _____

Group #: _____ ID #: _____

Secondary dental insurance (e.g. spouses insurance), if applicable:

Subscriber's name: _____ Employer, occupation:_____
LAST FIRST M

Subscriber's date of birth: _____ Subscriber's social security #: _____
MONTH DAY YEAR

Insurance company: _____ Insurance company phone #: _____

Insurance company address: _____

Group #: _____ ID #: _____

Dental Insurance Authorization

I hereby authorize payment directly to Pearl Dental of the group insurance benefits otherwise payable to me. I understand that insurance estimates are provided solely as a courtesy, and are not a guarantee of payment. I understand that I am responsible for all costs of dental treatment. I hereby authorize Pearl Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____ Date: _____ State, driver license #: _____
PATIENT OR RESPONSIBLE PARTY

pearl DENTAL

Dental/Medical History

Purpose of Today's Visit:_____

How often do you brush? _____ How often do you floss? _____

Date of last dental visit? _____ Date of last Cleaning? _____

Have you had complications with previous dental treatment? Please describe_____

_____

Is there anything you would like to change about the appearance of your teeth?_____

Please mark all that apply: Have you been diagnosed as needing a *DEEP CLEANING* in the past? ☐ YES Approx. Date_____ ☐NO

☐ Toothache
☐ Loose, Chipped, Cracked or Broken Fillings or teeth
☐ Food Traps
☐ Bleeding or Pain with Flossing
☐ Clench or Grind Teeth
☐ Soreness of Facial Muscles
☐ Headaches
☐ Tooth Sensitivity
☐ Cold/Hot
☐ Biting/Chewing
☐ Touch
☐ Sweets
☐ Gums Bleed with Brushing/Flossing
☐ Staining/Spots on teeth
☐ Sleep Apnea/Snoring
☐ Sinus Problems/Infection
☐ Bad Taste/ Breath
☐ Mouth Sores
☐ Worn Braces
☐ Teeth Have Shifted
☐ Worn retainers or Night Guard
☐ Other _____

Medical History

Have you ever been hospitalized? Explain_____

Name of Physician:_____Phone:_____

Name of Pharmacy of Choice_____Phone:_____

Please mark all that apply:

☐ I Require Pre-medication Before Dental Work
☐ Allergic to Latex
☐ Allergic to Penicillin
☐ Allergies Other_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bisphosphonate Meds (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Didronel)
☐Blood Disease
☐ Cancer
☐ Diabetes ☐ Type I ☐ Type II
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding or Take Blood Thinners
☐ Fainting
☐ Glaucoma
☐ Head Injury
☐ Heart Attack
☐Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Low Blood Pressure
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Pacemaker
☐ Pregnant or trying
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Emphysema/COPD
☐ Osteoporosis
☐ Persistent Swollen Neck Glands
☐ Immunosuppression
☐ Other

Please List ALL Medications and Supplements _____

_____

I have read and understand the above. Any questions I had about this form have been answered. I understand it my responsibility to fill out the form correctly and completely.

X_____ _____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **PRINTED NAME** **DATE**

Doctor's Findings:_____

_____

_____ _____ _____

_____ ***Signature of Doctor*** ***Date***