ALIANA
FAMILY DENTAL

REGISTRATION FORM

First Name _____ Last Name_____ Middle Name _____

Preferred Name_____ How did you hear about our office? _____

Address: _____

City, State, Zip_____ Email_____

Home Phone _____ Cell Phone _____ Work Phone_____

Date of Birth _____ Social Security # _____ Sex: Male Female (circle one)

Reason for Today's Visit_____

RESPONSIBLE PARTY (if Different from Above)

Name _____ Relationship _____

Address (If Different) _____

Home Phone _____ Cell Phone _____ Work Phone_____

Date of Birth _____ Social Security # _____ Sex: Male Female (circle one)

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

INSURANCE

Do you have Insurance? Yes or No Policy Holder: _____ Relationship: _____

Policy Holder DOB_____ Employer _____

Ins Carrier _____ ID#_____ Group Number_____

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MEDICAL HISTORY

All information you supply to the office on this form and the subsequent interview with the dentist and information received from your physician or any other source will be held in the strictest confidence and will not be disclosed without your express and written permission.

PATIENT NAME: _____ DATE: ____/____/_____ SOCIAL SECURITY #: _____-____-_____

Do you now, or have you ever had, any of the following conditions?

- ☐ AIDS/HIV (+)
- ☐ ANEMIA
- ☐ ARTHRITIS/GOUT
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ BREATHING PROBLEMS
- ☐ BRUISE EASILY
- ☐ COLD SORES
- ☐ CONGENITAL HEART ISSUE
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURE
- ☐ EXCESSIVE BLEEDING
- ☐ EXCESSIVE THIRST
- ☐ FAINTING or DIZZINESS
- ☐ GLAUCOMA
- ☐ HEART DISEASE
- ☐ HEMOPHILIA
- ☐ HEPATITIS A, B, or C
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HISTORY OF CANCER
- ☐ JAUNDICE
- ☐ ANXIETY/DEPRESSION
- ☐ JAW JOINT PAIN
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ RADIATION TREATMENT
- ☐ RENAL DIALYSIS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATOID ARTHRITIS
- ☐ SCARLET FEVER
- ☐ SEASONAL ALLERGIES
- ☐ SICKLE CELL ANEMIA
- ☐ ANGINA
- ☐ COPD/EMPHYSEMA
- ☐ HISTORY OF STROKE
- ☐ OSTEOPOROSIS
- ☐ SINUS ISSUES
- ☐ SMOKER/TOBACCO
- ☐ STOMACH ISSUES/GERD
- ☐ SWELLING OF LIMBS
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ TUMORS/GROWTHS
- ☐ ULCERS
- ☐ OTHER: _____

Are you allergic or have had any issue to any of the following?

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ ERYTHROMYCIN
- ☐ LATEX allergy
- ☐ DENTAL ANESTHETIC
- ☐ PENICILLIN
- ☐ SULFA DRUGS
- ☐ CLINDAMYCIN
- ☐ AZITHROMYCIN
- ☐ OTHER_____
- ☐ OTHER_____
- ☐ OTHER_____

WOMEN: ☐ Pregnant ☐ Taking birth control ☐ Nursing/Breastfeeding

Please list all medications and their dosages: _____

_____

_____

Are you now under the care of a physician? YES / NO If yes, for what? _____

Physician's name, address, phone number: _____

_____

Please indicate if you've had any of the following:

- ☐ Complications from previous dental treatment. If yes, what? _____
- ☐ Previous hospitalizations. If so, for what/when? _____
- ☐ An unfavorable reaction to dental anesthetics. If so, what? _____
- ☐ Previous orthodontic treatment/braces. If so, when? _____

If you could change anything about your smile, what would it be? _____

I certify that I have answered all of the above to the best of my ability and I have answered truthfully.

Patient or legal guardian's signature: _____ Date: _____

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DENTAL HISTORY

Reason for today's visit _____
Dental anxiety 0-->10_____Date of last dental visit _____
Former dentist name (optional) _____Date of last dental X-rays_____

Past dental experience (circle one) – Excellent Positive Neutral Negative Horrible

Please **circle** to indicate if you have had any of the following:

bad breath	bleeding gums	blisters on lips or mouth
fingernail biting	food collection between teeth	grinding teeth
gums swollen or tender	jaw pain or tiredness	lip or cheek biting
mouth breathing	loose teeth or broken fillings	dry mouth
orthodontic treatment	pain around ear/TMJ area	periodontal treatment
sensitivity to cold/hot	sensitivity to sweets	sensitivity when biting
sores in your mouth	chewing on one side of mouth	cigarette pipe or cigar smoking
clicking or popping jaw	burning sensation on tongue	

Does food get caught in your teeth? Yes / No
Do you have frequent headaches, neck aches, or shoulder aches? Yes / No
Do you clench or grind your teeth? Yes / No
Have you experienced any pain or soreness in the muscles of your face? Yes / No
Have you experienced any pain or soreness in the muscles around your ear? Yes / No
Does your jaw click or pop? Yes / No
Have you ever had or been evaluated for orthodontic treatment? Yes / No
Do you now or have you ever experienced pain/discomfort in your jaw joint? Yes / No
Do you have any missing or extra permeant teeth? Yes / No
Do you use an electric toothbrush? Yes / No

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

Do any of your teeth hurt? Yes / No If Yes, please explain_____

Is there anything about your teeth or smile that you would like to change such as dark colored or crooked teeth, unsightly silver fillings, gummy smile, under bite, overbite, etc.? Yes / No

If Yes, please explain _____

Any serious trouble associated with any previous dental treatment? Yes / No

Have you ever had an injury to your face, mouth, teeth or chin? Yes / No

Anything else you would like the dentist to know?_____

_____

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

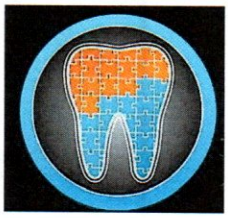
How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)



Comfort Menu

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
    - Which would you prefer? ☐ Tylenol ☐Advil ☐Other:_____

- We provide various levels of sedation to ease your mind.
    - Would you benefit from a sedative? ☐ Yes ☐ No
      If yes, we work with: ☐Nitrous Oxide (Laughing Gas)
      ☐ Oral Sedation (Deep sleep)
      (Note: with mild sedative, you will need someone to drive you to/from the appointment)

- Our treatment rooms are equipped with smart TV's that have Netflix and Pandora. Please let us know if you would like us to put something on for you, or if you would like the remote to look through and find the right thing just for you.

- Blankets help keep you warm and relaxed through your visit.
    - Would you like a blanket? ☐ Yes ☐ No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
    - Would you like a pillow? ☐ Yes ☐ No

- Is there anything else we can do to make your visit more comfortable?

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Please Handle Me with Care

Patient Name: _____

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please check all that apply:

- ☐ I gag easily
- ☐ Pain relief is a top priority for me
- ☐ My teeth are very sensitive
- ☐ I don't like shots (or I've had a bad reaction to shots)
- ☐ I feel out of control when I'm lying down for a long time
- ☐ I hate the noise of the drill or that tool that makes the picking and scraping noise
- ☐ I get nervous around doctors
- ☐ I am interested in conscious sedation (nitrous oxide with oxygen, commonly called laughing gas, produces a mild sedation that is helpful in decreasing anxiety)
- ☐ I am interested in oral sedation: for adults who need a deeper state of sedation.
- ☐ I have health problems and questions that we need to discuss
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision
- ☐ I want to know the cost up front

On a scale of 1-10, what do you value most about your oral health?

____ Function

____ Longevity

____ Esthetics

____ Comfort/ Freedom from pain

On a scale of 1-10, what do you value the most from your dental team?

____ Quality

____ Value

____ Comfort/Avoiding pain

____ Respecting Time

NO-SHOW & CANCELLATION POLICY

PRINT NAME: _____

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you.

Like many offices, this office does call to confirm your appointment. If you are unable to make an appointment as scheduled, please notify the office. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

You will be charged a **$25.00 fee** if you fail to show up for your appointment or give a 48-hour notice to cancel or reschedule your appointment. Before making another appointment, you will need to pay the cancellation fee on your account. Please note our office hours Monday - Thursday 8:00 am to 6:00 pm and closed from 1:00 pm to 2:00 pm for lunch. Leaving a message over the weekend, during non-business hours or via text does not qualify as notice of cancellation. You will be marked as a NO-SHOW, and the fee will be applied to your account.

By signing below, you are acknowledging that you have not only read the above cancellation agreement, but that you understand it. Should you find that you have further questions or concerns please speak to the receptionist or office manager.

DATE: _____

SIGNATURE: _____

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INSURANCE DISCLOSURE AND AGREEMENT

Our office strives to be up to date with most insurance companies' benefits and policies. There are hundreds of different insurance companies and different plans for individual employers. Our dentists at Aliana Family Dental are in-network with a number of insurance plans.

As a courtesy to our patients, we will call your insurance carrier and get a detailed breakdown of your benefits. We will explain these benefits to you to the best of our ability. Before any services are rendered, we will give you a treatment plan which is only an **ESTIMATE** of what your insurance will pay towards your treatment. Most insurance plans do not pay 100% of your cost of treatment. You are responsible for estimated co-pays at the time of service and will be responsible for any balance remaining after insurance payment regardless of reimbursement. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. We are committed to helping you maximize your insurance benefits.

It takes 2-8 weeks for your insurance company to send us an explanation of benefits or an EOB. This will detail how much was actually paid on the claim.

Our relationship with you is very important to us. We do our best to give you correct information. Sometimes, though, we cannot foresee policy changes which may be put into effect by your insurance carrier. And, nor do we have control over how your insurance company will process your claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all the charges.

There are instances when your insurance company issues overpayments on claims which will leave a credit on your account to use for future treatment unless directed otherwise. In some cases, the credit may need to be returned to your insurance carrier. When requested or necessary we will issue a refund for the credit you have on your account.

I have read and understand this financial policy.

Patient/Guardian Name (please print) Patient/Guardian Signature Date

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FINANCIAL POLICY

Welcome to Aliana Family Dental. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, Discover, American Express, money orders or registered checks.

EMERGENCY PATIENTS:
Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

DENTAL INSURANCE:
Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. We cannot render services on the assumption that our charges will solely be paid by an insurance company. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment.

ACCOUNT BALANCES:
If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of the patient examination and may change at any time according to contracted fees with your insurance company.

APPOINTMENT CANCELLATION POLICY:
Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not cancelled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a seventy-five-dollar ($75) fee. Any missed appointment 2 hours or more in length will incur a one hundred and fifty-dollar ($150) fee. This fee will not be covered by your insurance company.

PAYMENT PLANS:
Payment plans and financial arrangements *may* be available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

Patient/Guardian Name (please print) Patient/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

Purpose: This form is used to obtain acknowledgement of receipt of our *Notice of Privacy Practices* or to document our good faith effort to obtain that acknowledgement. Please note that it is your right to refuse to sign this acknowledgement.

I, _____, have received a copy of this office's *Notice of Privacy Practices*.
Patient name (please print)

_____
Patient signature

_____
Date

OR

_____
Signature of personal representative

Authority of Personal Representative to sign for patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

~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):

_____