TIME 09:15 AM DATE 2/22/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

Emergency Contact:

Contact Phone:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Comprehensive Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? If yes, who is your physician?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a head, neck or jaw injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs? If yes, please list or provide copy.	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for osteoporosis?	○ Yes ○ No	If yes
Do you use tobacco? If yes, please explain type, amount and duration of tobacco use.	○ Yes ○ No	If yes
Do you currently pre-medicate with an antibiotic prior to dental treatment? If yes, why?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other allergies?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Renal Dialysis	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Ulcers	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Stent Placement	○ Yes ○ No
Pre-Medicate	○ Yes ○ No						

Have you ever had any serious illness not listed above?	○ Yes ○ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Time 8:46 AM | Dr. Chelsea Mason Dental | Date 2/22/2018

Dental History

Patient Name: | Birth Date: | Date Created:

Welcome!

So that we may provide you with the best possible care please complete this dental history form. All information is completely confidential.

Dental History

What is the reason for your visit today?

When was your last dental cleaning?

Previous dentist's name and contact information:

How often do you brush your teeth?

How often do you floss?

Do you use topical fluoride? ○ Yes ○ No

What dental aids do you use (waterpick, toothpick)? Comment

Do you experience any of the following:

Sensitivity to Hot or Cold?	○ Yes ○ No	Bad taste?	○ Yes ○ No	Sensitivity to Sweets?	○ Yes ○ No
Cold sores?	○ Yes ○ No	Change in your bite?	○ Yes ○ No	Sensitivity to biting?	○ Yes ○ No
Bleeding gums?	○ Yes ○ No	Food caught between teeth?	○ Yes ○ No	Blisters or canker sores?	○ Yes ○ No
Loose teeth?	○ Yes ○ No				

Please explain if you answered yes to any of the above questions:

Do you:

Clench or grind your teeth?	○ Yes ○ No	Mouth breathe?	○ Yes ○ No	Snore?	○ Yes ○ No
Bite your lips or cheeks?	○ Yes ○ No	Have jaw pain?	○ Yes ○ No	Hold objects with your teeth?	○ Yes ○ No
Have a sleeping disorder?	○ Yes ○ No				

Have you experienced any of the following:

Clicking, popping of jaw?	○ Yes ○ No	Difficulty opening or closing?	○ Yes ○ No	Headaches, neck aches?	○ Yes ○ No
Difficulty chewing?	○ Yes ○ No	Sore head or neck muscles?	○ Yes ○ No		

Please explain if you answered yes to any of the above questions:

Have you ever had:

Orthodontic Treatment?	○ Yes ○ No	Periodontal Treatment?	○ Yes ○ No	Oral Surgery?	○ Yes ○ No
Placement of an implant?	○ Yes ○ No	A bite plate or mouth guard?	○ Yes ○ No		

If you answered yes to any of the above questions and have additional comment, please explain:

Concerning your teeth:

Are you happy with how they look?	○ Yes ○ No
Do you want to replace silver fillings?	○ Yes ○ No
Do you want to keep them your whole life	○ Yes ○ No

Do you feel nervous about having dental treatment? ○ Yes ○ No If yes

Have you ever had an upsetting dental experience? ○ Yes ○ No If yes

Have you ever been told to take a pre-medication prior to dental treatment? ○ Yes ○ No If yes

Is there anything else about dental treatment that you would like us to know? ○ Yes ○ No If yes

FINANCIAL POLICY
DR. CHELSEA MASON DENTAL

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is our financial policy which we require you to read, understand and sign prior to any treatment. All patients must complete our Medical History, Dental History and Insurance Information forms before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, OR ALL MAJOR CREDIT CARDS.
- WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL THROUGH APPROPRIATE LENDING INSTITUTIONS.
- ANY UNPAID BALANCE ON YOUR ACCOUNT EXCEEDING 30 DAYS PAST DUE WILL BE SUBJECT TO A SERVICE FEE OF 1 ½% PER MONTH (18% ANNUAL).

TO OUR PATIENTS WITH DENTAL INSURANCE, YOU ARE MOST FORTUNATE; REGARDING INSURANCE REIMBURSEMENT:
This office is happy to cooperate with families who are covered by dental insurance. We only ask that you read and understand your policy to be sure that you are aware of any limitations of benefits provided.

DENTAL INSURANCE IS DESIGNED TO ASSIST IN THE COST OF CARE, BUT NOT ELIMINATE IT ENTIRELY.
We will gladly complete forms pertaining to your claim. This involves a great deal of paperwork, but we are happy to provide this service, because we realize how important it is for our patients. We accept direct insurance payments from most major dental insurance carriers. We have no control over what may be covered or the length of time the insurance company takes to process the claim. Since your dental insurance is a contract between you and your insurance company, the ultimate responsibility rests on you for any dental charges incurred. If your insurance company has not paid your account in full within 45 days, payment in full of the balance will be your responsibility. Your co-payments (the portion not paid under your insurance plan) and deductible are due prior to/at the time of treatment. Please feel free to discuss your dental insurance coverage with us.

ADULT PATIENTS:
Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS:
The adult accompanying a minor and parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency procedures will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check at the time of treatment has been verified.

MISSED APPOINTMENTS:
We respect your time and ask that you reciprocate. When we schedule the appointment for your service, we are reserving that time specifically for you, rendering that time unavailable for any other patient that may need our services. Please have the courtesy to inform us in advance if you are unable to keep your specific appointment time. Unless informed at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $70.00 per visit. Please help us serve you better by keeping scheduled appointments and arriving on time.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I understand that where appropriate, credit bureau reports may be obtained. I have read and agree to the Dr. Chelsea Mason Dental Financial Policy.

X_____ _____
Signature of responsible party Date

X_____ _____
Signature of co-responsible party Date

Effective April 1, 2017

GENERAL CONSENT FOR TREATMENT
DR. CHELSEA MASON DENTAL

I authorize Dr. Chelsea Mason and her designated staff to perform examinations for the purpose of dental cleanings, general dentistry, cavity detection, diagnosis and treatment planning, which may include filling of cavities, tooth extraction, crown preparations, and/or other treatments. Furthermore, I authorize the taking of all x-rays, study models, digital scans and photographs required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

I understand the nature of my dental condition(s), the potential consequences of this condition if left untreated and the likelihood that these consequences will actually occur. I understand the appropriate treatment and alternative treatment options for my condition, the risks involved with each of these treatment options and their likelihood of occurring.

I was given the opportunity by Dr. Mason to ask questions regarding my condition and the suggested treatment and the treatment alternatives. I understand that if I have any further questions or concerns to contact Dr. Mason. I understand that I can discuss any additional questions or concerns, and she has answered all my questions to my satisfaction.

I understand that I could obtain a second opinion and/or further consultation from another dentist if I so desire. At no time did Dr. Mason provide me with any warranty or guarantee as to the specific results of the proposed treatment for my condition.

Taking all of the above information into consideration, being at least 18 years of age and otherwise competent to make my own medical decisions and fully understanding the nature and possible consequences of my dental condition, the course of treatment and the risks inherent in such treatment, I consent to the recommended dental treatment.

X_____ _____
Signature of responsible party Date

X_____ _____
Signature of co-responsible party Date