Crown Town DENTAL

Last Name _____ **First Name** _____ MI _____

DOB _____ **Age** _____ **Sex** (please circle) **M** or **F** **SSN** _____ (Required for insurance verification)

Address _____ **City** _____ **State** _____ **Zip** _____

Email Address: _____ **Primary Phone:** (_____)_____

Primary Insurance Co _____ **Secondary Ins Co** _____ **Insurance cards must be provided***

Subscriber Employer (if applicable) _____ **Subscriber SSN** _____

Insurance Subscriber_____ **Subscriber DOB** _____

If patient is a minor: Name of Parent _____ Parent's DOB_____

Emergency Contact _____ **Emergency Contact Phone Number** (_____)_____

Is this patient capable of making their own medical decisions? If not, are you able to on their behalf?

_____

Guardian name: _____ **Guardian Phone #** (_____)_____

Where did you hear about us? (Please Circle)

Google/Yelp Practice Website Facebook Family/Friend/Coworker Internet Other

Who can we thank for your visit today*?*

_____

Dental History **(On a scale of 1-5, with 5 being the highest rating)**

How important is your dental health to you? 1 2 3 4 5

Where would you rate your current dental health? 1 2 3 4 5

What would you like to change about your smile? (Circle any that apply)

Color Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

Would you like to learn more about your **Invisalign** options? _____

Name of your previous dentist _____

Seth Cohen DDS *(p) 913.341.6767 (f) 913.341.8077* *office@crowntowndental.com*

Dental History Continued (Please circle any and all of the following conditions that apply to you)

Appearance
Discolored teeth
Worn teeth
Misshaped teeth
Crooked teeth
Spaces
Overbite
Flat teeth

Pain/Discomfort
Sensitivity (hot,cold,sweet)
Pressure
Broken teeth/fillings
Worn Teeth
Dry Mouth

Function
Grinding/Clenching
Headaches
Jaw Joint (TMJ) pain/popping
Bad Bite
Speech Impediment
Mouth Breathing
Difficulty Opening/Closing
Difficulty Chewing

Periodontal (Gum) Health
Bleeding/Swollen Gums
Bad Breath
Loose tipped, shifting teeth
Previous perio/gum disease

Habits
Thumb Sucking
Nail-biting
Cheek/Lip Biting
Chewing on ice/foreign objects

Sleep Pattern or Conditions
Sleep Apnea
Snoring
Daytime Drowsiness

Social
Tobacco use
Alcohol Frequency _____
Drug Frequency _____

PREVIOUS COMFORT OPTIONS
Nitrous Oxide
Oral Sedation (Pill)
IV Sedation

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____

Cancer
Type_____
Chemotherapy
Radiation Therapy

Cardiovascular
Angina (chest pain)
Artificial Heart Valve
Heart Conditions
Heart Surgery
High/Low Blood Pressure
Mitral Valve Prolapsed
Stroke
Pacemaker
Rheumatic Fever
Scarlet Fever

Endocrinology
Diabetes
Hepatitis A/B/C
Jaundice
Kidney Disease
Liver Disease
Thyroid Disease

Respiratory
Emphysema
Asthma
Sinus Issues
Tuberculosis

Musculoskeletal
Arthritis
Artificial Joints
Rheumatoid Arthritis

Mental
Autism Spectrum
Anxiety
Depression
Dizziness
Drug/Alcohol Addiction
ADD/ADHD
Intellectual Disabilities
Seizures
Psychiatric Illness

Viral Infections
AIDS
HIV Positive
HPV

MEDICAL ALLERGIES (**circle any and all that apply**)
Antibiotics (Penicillin/Amoxicillin/Clindamycin)
Opioids (Percocet, Oxycodone, Codeine)
Latex
Local Anesthetics
Other _____

Please list any physical/mental disabilities:
_____
_____

Do you require a Pre-Medication prior to dental appointments? If so, which medication?
_____

Are you currently pregnant or breastfeeding? _____

Have you had any serious illness, operation, or hospitalization in the past 5 years?
_____

Consent: *The undersigned hereby authorizes Seth J. Cohen DDS LLC to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions. I certify that I have read and understand the questions asked in this Patient Registration and Medical History section on this form. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.*

Sign here:_____ **Today's Date:**_____
Signature of Patient/Legal Guardian

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NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request a copy of the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Crown Town Dental reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____ _____

Patient Name (Printed) **Today's Date**

_____ _____

Signature of Patient / Responsible Party **Relationship to Patient (if other than Self)**

PAYMENT FOR SERVICES

We expect full payment at the time of service, unless another financial agreement is made in advance. For your convenience, we accept Mastercard, American Express, Visa, Discover, check, cash, and Care Credit.

REGARDING INSURANCE

Crown Town Dental will gladly file your insurance, as a courtesy to you, but your estimated portion, including co-pays and deductibles, is due at the time services are rendered. Your insurance is a contract between the insurance company, your employer and you. We are, typically, not a party in this contract. Please be aware that some, and perhaps all, of the services we provide to you may be non-covered services and not considered "reasonable and necessary" under your dental insurance. If for any reason your insurance carrier does not pay the full estimated benefit, the remaining portion will become the responsibility of the patient or responsible party.

CANCELLATION POLICY

When we make your appointment, we are reserving a room for your particular needs. If you must change an appointment, we ask that you give us at least two business days. This courtesy makes it possible to give your reserved room to another patient who would like it. *After the second missed appointment, without a two business day notice, we will be unable to reserve a room and time for you***.** We will however add you to our call list and call you with any appointments that open up the same day. Repeated cancellations or missed appointments will result in loss of future appointment privileges. **Patients who no show or cancel sedation appointments within *one week* of the scheduled procedure will be charged a fee of $75, which is non-refundable.**

LATE PAYMENT PENALTY

Any account 90 days past due may be turned over to collections and will be charged 40% of the balance due for collection fees.

CONSENT TO RELEASE OF PATIENT INFORMATION AND RECORDS

I hereby give my permission for the release of my records, including but not limited to radiographs, photographs and impressions, for the purpose of professional consultation, referrals to another dental or specialist's office and/or fabrication of dental prosthesis or appliances by dental laboratories. Transmission of these records may be completed via mail, fax and/or unencrypted email. No information obtained from the medical history form will be transmitted via unencrypted email; however, patient name, age, birthdate and gender may be used to identify radiographs and photographs.

_____ _____

Patient Name (Printed) **Today's Date**

_____ _____

Signature of Patient / Responsible Party **Relationship to Patient (if other than Self)**

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