Crown Town DENTAL

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

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

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

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

**Employer** _____ **Marital Status: (***Please Circle***)** **Married** **Single** **Divorced** **Widowed**

**If married, please include spouse information below:**

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

**DOB** _____ **Primary Phone** (_____)_____

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

**Subscriber Name** _____ **Subscriber DOB** _____ **Subscriber SSN**_____

**Member ID**_____ **Group #** _____ **Employer** _____

**Is this patient their own legal guardian?** *(please circle)* **YES** or **NO**

**Legal Guardian Name:** _____ **Legal Guardian Phone:** (_____) _____-_____

**Legal Guardian Email:** _____ ***Please provide legal guardianship paperwork***

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

**Emergency Contact Name** _____ **Emergency Contact Phone Number** _____

**Where did you hear about us?** (*Please Circle*)

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

## 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? _____

## ***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 other health issues or conditions:**
_____
_____

**Height:** _____ **Weight:** _____

**Preferred Pharmacy:** _____
**Phone Number:** (_____) _____-_____

**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?**
_____

_____ _____
**Patient Name (Printed)** **Patient DOB**

_____ _____
**Name of person completing this form (if other than Self)** **Relationship to Patient (if other than Self)**

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

# GENERAL CONSENT

*I authorize the doctors and clinical staff of Seth J. Cohen DDS LLC (Crown Town Dental) to perform a dental examination and any diagnostic procedures deemed necessary for the evaluation of my oral health. This may include, but is not limited to, digital radiographs (X-rays), intraoral and extraoral photographs, digital scans, study models, periodontal charting, and other diagnostic aids. I authorize the doctors of Crown Town Dental to provide routine dental care, preventive services, restorative treatment, local anesthetic, medications, and other treatment that is clinically appropriate based on my examination, diagnosis, and treatment plan. I understand that certain procedures, including but not limited to oral surgery, sedation, implants, endodontic treatment, periodontal surgery, cosmetic procedures, and other specialized treatment, may require separate procedure-specific informed consent before treatment is performed. I understand that the administration of local anesthetics and medications carries certain risks and potential complications, which have been explained to me or will be discussed before treatment when appropriate. I understand that the practice of dentistry is not an exact science and that no guarantees or warranties have been made regarding the outcome of any examination, diagnosis, or treatment. I certify that the information I have provided on my Patient Registration and Medical History forms is complete and accurate to the best of my knowledge. I understand that withholding or providing inaccurate information regarding my medical history, medications, allergies, or health conditions may affect my treatment and could place my health at risk. I agree to promptly notify Crown Town Dental of any changes in my medical history, medications, pregnancy status, insurance information, or contact information.*

## FINANCIAL POLICY

Payment is due at the time services are rendered unless other financial arrangements have been made in advance. Accepted forms of payment include cash, personal checks, Visa, Mastercard, American Express, Discover, and CareCredit.

*Any estimated patient responsibility, including co-payments, deductibles, and amounts not covered by insurance, is due at the time of service unless otherwise agreed upon in writing. A returned check fee of **$35.00** will be assessed for any check returned by the bank for insufficient funds or any other reason. Accounts with outstanding balances that remain unpaid for ninety (90) days or more may be referred to a collection agency or other lawful means of collection. If an account is referred for collection, the patient or responsible party agrees to be responsible for any applicable collection costs and fees, including collection fees of up to twenty-five percent (25%) of the outstanding balance, as permitted by law.*
*The practice reserves the right to require payment of any outstanding balance prior to scheduling future appointments.*

## INSURANCE BENEFITS

*As a courtesy, Crown Town Dental will file dental insurance claims on your behalf when current insurance information is provided. Filing insurance claims is a courtesy and does not alter the patient's financial responsibility. Your dental insurance policy is a contract between you, your employer (if applicable), and your insurance carrier. Crown Town Dental is not a party to that contract. Insurance benefits are estimated based on the information available to us at the time of treatment and are not a guarantee of payment. Any estimated patient responsibility, including co-payments, deductibles, co-insurance, and services not covered by your dental plan, is due at the time services are rendered. Pre-authorizations are submitted at the discretion of the practice and are not a guarantee of payment or coverage. A pre-authorization is an estimate based on the information available to your insurance carrier at the time it is reviewed. Final payment is determined only after treatment has been completed and the claim has been processed according to your specific plan benefits and eligibility on the date of service. Please be aware that some or all recommended treatment may be considered non-covered, not medically or dentally necessary, frequency limited, or otherwise excluded by your insurance plan. Any portion not paid by your insurance carrier remains the responsibility of the patient or responsible party, regardless of the status of any insurance claim. We will make reasonable efforts to obtain payment from your insurance carrier. If your insurance claim remains unpaid or unresolved sixty (60) days after the date of service, the outstanding balance will become the responsibility of the patient or responsible party. Payment is expected at that time. Should your insurance company subsequently issue payment after you have paid your balance, any applicable overpayment will be promptly refunded to you. Upon request, we will gladly provide any documentation reasonably necessary for you to communicate directly with your insurance carrier regarding your claim or reimbursement.*

**By signing below, I acknowledge that I have read, understand, and agree to the General Consent for Examination and Treatment, Financial Policy, and Insurance Policy of Crown Town Dental.**

**Sign Here:** _____ **Today's Date:** _____

*Signature of Patient/Legal Guardian*

# OFFICE POLICIES

**Appointment, Cancelation & Late Arrival Policy**

Appointment times are reserved specifically for each patient. If you need to cancel or reschedule your appointment, we request a minimum of two (2) business days' notice so that we may offer your reserved appointment time to another patient.

Patients are responsible for confirming appointments when requested. Appointments that remain unconfirmed at least twenty-four (24) hours before the scheduled appointment may be canceled at the discretion of the practice.

Patients who repeatedly fail to confirm appointments or have a history of missed appointments may be required to schedule appointments individually rather than reserving multiple future appointments.

Patients arriving more than fifteen (15) minutes after their scheduled appointment time may be required to reschedule. This policy helps us remain on schedule and provide quality care to all patients. Exceptions may be made at the discretion of the treating doctor.

Repeated missed appointments, late cancellations, failure to confirm appointments, or excessive tardiness may result in limited scheduling privileges, cancellation of future appointments, or dismissal from the practice.

Sedation appointments require significant scheduling coordination and are often reserved months in advance. Patients who cancel a sedation appointment with less than seven (7) business days' notice or fail to appear for their scheduled sedation appointment will be assessed a non-refundable $100 scheduling fee.

**Safe Patient Transfer Policy**

Crown Town Dental is committed to providing dental care to all patients while maintaining a safe environment for patients, visitors, and employees. For the safety of our patients and staff, our clinical team does not manually lift or physically transfer patients between wheelchairs, mobility devices, vehicles, or the dental chair. Patients requiring assistance with transfers must be able to transfer independently or be accompanied by a caregiver or companion who can safely provide the necessary assistance. Certain dental procedures require the patient to be safely positioned in the dental chair. If a safe transfer cannot be accomplished, treatment may need to be modified, postponed, or referred to another facility that is better equipped to safely provide the required care.

**Patient Conduct**

Crown Town Dental is committed to providing a safe, respectful, and professional environment for our patients and team members. Abusive, threatening, discriminatory, harassing, intimidating, sexually inappropriate, or disruptive behavior toward staff, providers, or other patients will not be tolerated and may result in cancellation of the appointment, dismissal from the practice, or involvement of law enforcement when appropriate.

**Minor Patients**

A parent or legal guardian may be required to accompany minor patients to appointments and must be available to provide consent for treatment when necessary. The practice reserves the right to refuse or discontinue treatment when, in the professional judgment of the treating doctor, it cannot be provided safely, appropriately, or in accordance with the applicable standard of care.

**Sign Here:** _____ **Today's Date:** _____

*Signature of Patient/Legal Guardian*

# HIPAA Acknowledgment

I acknowledge that I have been offered access to Crown Town Dental's Notice of Privacy Practices. I understand that a printed copy is available upon request at the office and that the Notice is posted in the reception area and is available on their website.

## Authorization to Release Patient Information

To protect your privacy, Crown Town Dental will not discuss your protected health information, treatment, appointments, insurance, or financial information with anyone other than you unless otherwise permitted or required by law or authorized by you in writing.

By signing below, I authorize Crown Town Dental to discuss my dental treatment, appointments, insurance information, billing, and financial account with the individuals listed below.

This authorization will remain in effect until I revoke it in writing.

**Please list the full name, relationship to you, and phone number of any individual(s) you authorize Crown Town Dental to discuss your treatment, appointments, insurance, or financial information with.**

**If you do not authorize anyone, please write "NONE" on the first line below**

**Name**_____ **Phone Number**_____ **Relationship**_____

**Name**_____ **Phone Number**_____ **Relationship**_____

**Name**_____ **Phone Number**_____ **Relationship**_____

**Sign Here**: _____ **Today's Date**: _____

*Signature of Patient/Legal Guardian*