



DENTAL REGISTRATION AND INSURANCE

PATIENT INFORMATION

Date: _____ SS#: _____ Birthday: _____ Age: _____ Sex: M [] F []

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

PHONE NUMBERS & CONTACT INFORMATION

Home: (_____) _____ - _____ Work: (_____) _____ - _____

Mobile: (_____) _____ - _____ E-Mail: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Employer/School Phone: (_____) _____ - _____

Spouse's Name: _____ Spouse's Employer: _____

Who is responsible for this account? _____

Who may we thank for referring you? _____

In case of emergency, contact: _____ (_____) _____ - _____
NAME RELATIONSHIP PHONE

DENTAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#: _____ Effective Date: _____

Name of Employer: _____ Employer Phone: (_____) _____ - _____

Insurance Name: _____ Insurance Phone: (_____) _____ - _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Annual Maximum Benefit: _____

Do You Have Any Additional Insurance? Yes [] No []

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependents have insurance and assign directly to Pathway Dental all insurance benefits. I understand that I am financially responsible for all whether or not paid by insurance.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Patient Name: _____ Date: _____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ City: _____ State: _____

Date of last dental visit: _____ Date of last dental x-ray's: _____

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

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Badbreath Yes [] No []	Jaw pain or tiredness	Yes [] No []
Bleeding gums Yes [] No []	Lip or cheek biting	Yes [] No []
Blisters on lips or mouth Yes [] No []	Loose teeth or broken fillings	Yes [] No []
Burning sensation on tongue Yes [] No []	Mouth breathing	Yes [] No []
Chew on one side of mouth Yes [] No []	Mouth pain	Yes [] No []
Cigarette, pipe or cigar smoking/chewing tobacco Yes [] No []	Orthodontic treatment	Yes [] No []
Clicking or popping jaw Yes [] No []	Pain around ear	Yes [] No []
Dry mouth Yes [] No []	Periodontal treatment	Yes [] No []
Fingernail biting Yes [] No []	Sensitivity to cold	Yes [] No []
Food collection between the teeth Yes [] No []	Sensitivity to heat	Yes [] No []
Foreign objects in mouth Yes [] No []	Sensitivity to sweets	Yes [] No []
Grinding teeth Yes [] No []	Sensitivity when biting	Yes [] No []
Gums swollen or tender Yes [] No []	Sores or growths in mouth	Yes [] No []

MEDICAL HISTORY

Physician's Name: _____ Phone Number: (____) _____ Date of last visit: _____

Pharmacy Name: _____ Phone Number: (____) _____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS or HIV	Yes [] No []	Headaches	Yes [] No []	Fainting	Yes [] No []
Anemia	Yes [] No []	Heart Problems	Yes [] No []	Respiratory Disease	Yes [] No []
Arthritis	Yes [] No []	Hepatitis Type _____	Yes [] No []	Scarlet Fever	Yes [] No []
Back problems	Yes [] No []	Herpes	Yes [] No []	Shortness of Breath	Yes [] No []
Cancer	Yes [] No []	High Blood Pressure	Yes [] No []	Sinus Trouble	Yes [] No []
Chemical dependence	Yes [] No []	Kidney Disease	Yes [] No []	Stroke	Yes [] No []
Chemotherapy	Yes [] No []	Liver Disease	Yes [] No []	Swollen Neck Glands	Yes [] No []
Circulation Problems	Yes [] No []	Low Blood Pressure	Yes [] No []	Thyroid Problems	Yes [] No []
Cortisone Treatments	Yes [] No []	Nervous Problems	Yes [] No []	Tonsillitis	Yes [] No []
Diabetes	Yes [] No []	Persistent Cough	Yes [] No []	Tuberculosis	Yes [] No []
Empysema	Yes [] No []	Psychiatric Care	Yes [] No []	Ulcers	Yes [] No []

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH:

Artificial Heart Valve	Yes [] No []	Mitral Valve Prolapse	Yes [] No []
Heart Murmur	Yes [] No []	Blood Disease	Yes [] No []
Artificial Joint/Pins/Screws	Yes [] No []	Pacemaker	Yes [] No []
Hernia Repair	Yes [] No []	Congenital Heart Lesions	Yes [] No []
Bleeding abnormally with extractions	Yes [] No []	Rheumatic Fever	Yes [] No []

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:

Blood Thinners:

Coumadin Yes [] No []

Warfarin Yes [] No []

Osteoporosis Medications (Bisphosphonates):

Fosamax Yes [] No []

Actonel Yes [] No []

Boniva Yes [] No []

Evista Yes [] No []

Reclast Yes [] No []

Forteo Yes [] No []

ARE YOU ALLERGIC TO:

Aspirin Yes [] No []

Barbiturates Yes [] No []

Codeine Yes [] No []

Ibuprofen Yes [] No []

Latex Yes [] No []

Local Anesthesia Yes [] No []

Metals Yes [] No []

Penicillin Yes [] No []

Other: _____

HAVE YOU EVER HAD COMPLICATIONS FOLLOWING DENTAL TREATMENT? YES [] NO []

Please explain _____

PLEASE PRINT ALL MEDICATIONS NOW TAKING _____

ARE YOU PREGNANT OR NURSING? YES [] NO []



FINANCIAL POLICY

Thank you for choosing the office of Dr. Chad Sloan. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable as possible by offering several payment plans.

PAYMENT OPTIONS:

- Cash, Check, Visa , MasterCard, Discover
**Pathway Dental Charges \$75.00 for a returned check
- Convenient interest free monthly payment plans are available from Care Credit or the Lending Club. It only takes a few minutes to apply. We can do it for you in the office or you can apply at home on their websites, www.carecredit.com
- If there is an insurance estimate, your portion is due the day of treatment.
- For plans requiring multiple appointments, alternative payment arrangements may be provided.

INSURANCE

As a courtesy to you, we will file with your dental insurance carrier to help you maximize your benefits. The amount not covered by your insurance will be estimated, and you will be required to pay at the time of treatment. If we have not received payment from your insurance company within 60 days you will be responsible for full payment of your treatment. You can then collect directly from your insurance carrier. Ultimately, you are responsible for all fees not paid by your insurance.

COLLECTIONS

I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered, and I fail to immediately tender the monies due to Practice. I agree and understand in the event I do not pay practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of Marion County, Indiana and agree that Indiana law governs all matters arising out of this agreement.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry you want or need, and find the best financial solution for you.

Patient, Parent or Guardian Signature

Printed Patient Name

Date



Contact Information for Protected Health Information

I, _____, Date of Birth _____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

*Sensitive Protected Health Information (HIV-related information)

*You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship
NAME PHONE NUMBER RELATIONSHIP

Four sets of dashed lines for listing contact information.

You may leave Protected Health Information on my answering machine/voicemail Phone Number _____

You may send me a text message at _____

You may email me (unencrypted) for dental appointments at Email: _____

You may fax me dental information at _____

Other: _____

I have received a copy of this office's Notice of Privacy Practices.

Print Patient's Name: _____ Date: _____

Patient or Guardian Signature: _____

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:

- _____ The individual refused to sign.
_____ Communication barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.