

PATIENT REGISTRATION

Patient Name (Last, First, Middle Initial)	Date of Birth	Social Security Number	Sex Male Female
			Marital Status Single Married
Address	City	State	Zip
<u>H</u> ome Phone:	What name do you prefer to be called?		
<u>W</u> ork Phone:			
<u>C</u> ell Phone:			
E-Mail Address (print clearly)			
Preferred method of Confirmation: ___ Phone call **Circle Best Contact: H W C ___ Text ___ Email			
Employer	Occupation	Relationship to Insured SELF SPOUSE CHILD OTHER	

PRIMARY DENTAL INSURANCE CARRIER

SECONDARY DENTAL INSURANCE CARRIER

Name of Policy Holder		Name of Policy Holder	
Date of Birth		Date of Birth	
Insurance Company Name		Insurance Company Name	
Member I.D. #	Group Number	Member I.D. #	Group Number
Employer	Occupation	Employer	Occupation

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

Name	Phone
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REFERRED TO THIS OFFICE BY:

Friend/Family Member: (so we can thank them) _____

Phone Book

Internet

Insurance List

Sign Out Front

Signature _____ Date _____

OFFICE NOTES

Patient Name _____

PATIENT MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well-being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. THANK YOU.

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? Please X If Yes

Latex Allergy	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Emotional Concerns/Psychiatric Care	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	Chronic Sinus Problems	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Bleeding or Blood Problem	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Herpes Simplex I (canker sores)	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	AIDS or AIDS Related Complex	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	Malignancies or Tumors	<input type="checkbox"/>

- Have you experienced an unusual or allergic reaction to any of the following: Penicillin, Codeine, Aspirin or any other drug?..... YES NO
- Have you ever experienced an unusual reaction to Dental Anesthetics(Novacaine) YES NO
- Have you had any prosthetic surgery such as: artificial heart valve replacement or an artificial hip or joint replacement?..... YES NO
- Have you received or are you currently receiving medication known as bisphosphonates (for example, zoledronic acid [Zometa] or pamidronate [Aredia]? YES NO
- Are you under any medical treatment or taking medication now?..... YES NO
- Are you now or ever been treated with chemotherapy or radiation?..... YES NO
- Do you smoke?..... Packs per day _____ YES NO
- Are you pregnant (women) Y N Birth control medication... YES NO

If you have marked any of the above with a yes, please give us a brief history:

Name of Physician: _____

Phone: _____

DENTAL HISTORY

How long has it been since your last dental cleaning? _____

What did you like most about your previous dentist? _____

What did you like least? _____

What are you expecting today? _____

Do you have any pain in your jaw upon opening or closing? _____ Tension Headaches? _____

FACIAL COSMETIC HISTORY

Have you ever had Botox, Dermal fillers or other facial cosmetic procedures before _____ When _____

Have you ever had a disease that affects your muscles or nerves? (ALS, Myasthenia Gravis, etc.) _____

What area of your face are you most concerned with? (Eyes, forehead, lips etc.) _____

Have you had any adverse reactions to Botox or dermal fillers? _____

Signature _____ Date _____ Updated _____

DES MOINES DENTAL CENTER
FINANCIAL AGREEMENT AND POLICIES

It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines:

OUR FINANCIAL POLICY:

Your portion of the payment is due at the time that services are rendered.

For your convenience, we offer several payment options: We accept Cash, Checks (NSF Fee \$75.), or Visa/Mastercard, Discover, American Express. We offer extended payment plan with prior credit approval. (Care Credit)

REGARDING INSURANCE:

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. It is the patient's responsibility to update the office with changes in your insurance company or policy. Our office is not a party to that contract and final responsibility of payment is yours. With current insurance information, we strive to determine benefits prior to treatment, which provides you with important deductible and co-payment information. As a courtesy to you, we will help process your insurance claims. If there is no payment from the insurance company with sixty (60) days, you will be expected to pay the balance in full. All accounts over ninety days (90) days will be subject to a finance charge of 1.0% per month, which is an annual rate of 12%

MEDIA USAGE:

I hereby permit Des Moines Dental Center to use any and all media forms including, but not limited to, photographs, copy, and xrays for use on the Des Moines Dental Center web site and other web sites belonging to Steven M Reeves, DDS

CANCELLATION POLICY:

There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then be allocated to those patients with immediate needs. In this way the office can best serve the needs of ALL patients. Bearing this in mind, our office requires a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours notice has been given to cancel an appointment, a \$75 fee will be assessed.

We at the Des Moines Dental Center look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the above policies of the Des Moines Dental Center and understand my responsibilities as a patient.

Patient Signature _____ Date _____