Restoration Dental Center

1180 7th Ave. MARION, IA 52302 PHONE (319) 423-9350

TO ALL OUR PATIENTS

Welcome! Thank you for selecting our office. It is our goal to provide for your dental needs as thoroughly and efficiently as possible. In addition, we will endeavor to make your visit with us a pleasant and comfortable one. Please read and complete the following materials, and don't hesitate to ask if you have any questions.

date_____

PATIENT REGISTRATION

Mr. Mrs. Ms. Dr. ○ ○ ○ ○ _____ (first,) ___ (mi,) _____ (last) (_____)_____ (home phone) (_____)_____ (cell phone)

_____ (street address / mailing address) (_____)_____ (work phone) _____ (ext.)

_____ (city,) ____ (state,) _____ (zip) _____ (social security number)

_____ (age) _____ (birth date) _____ (marital status) M ○ F ○ (sex) _____ (employer's name)

_____ (occupation) _____ (employer's address)

PERSON RESPONSIBLE FOR ACCOUNT

Same as above ○

Mr. Mrs. Ms. Dr. ○ ○ ○ ○ _____ (first,) ___ (mi,) _____ (last) (_____)_____ (home phone) (_____)_____ (cell phone)

_____ (street address / mailing address) _____ (relationship) (_____)_____ (work phone)

_____ (city,) ____ (state,) _____ (zip) _____ (social security number)

_____ (age) _____ (birth date) _____ (martial status) M ○ F ○ (sex) _____ (employer's name)

_____ (occupation) _____ (employer's address)

INSURANCE INFORMATION: DENTAL INSURANCE

_____ (**PRIMARY** company) ID#_____ _____ (social security number)

_____ (member's first name) _____ (last name) _____ (birth date) _____ (group)

_____ (**SECONDARY** company) ID#_____ _____ (social security number)

_____ (member's name) _____ (birth date) _____ (group)

INSURANCE INFORMATION: MEDICAL INSURANCE

_____ (**PRIMARY** company) ID#_____ _____ (social security number)

_____ (member's first name) _____ (last name) _____ (birth date) _____ (group)

_____ (**SECONDARY** company) ID#_____ _____ (social security number)

_____ (member's first name) _____ (last name) _____ (birth date) _____ (group)

PLEASE SEE OTHER SIDE TO COMPLETE FORM.....

MISCELLANEOUS INFORMATION

Referring dentist First Name _____ Last Name _____ physician's First Name _____ Last Name _____

Has any member of your family ever been a patient here? Yes **O** No **O**

if so, name/relationship _____ name/relationship _____

name/relationship _____ name/relationship _____

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize Dr. Shaw and his designated staff, to perform an oral examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of information acquired in the course of my examination and treatment. I authorize Dr. Shaw to obtain or release my treatment, insurance, billing and appointment information to the following individuals, in addition to my referring physician, until I revoke the authorization in writing:

1) _____ 2) _____

Insured or Guardian's Signature _____ Patient's Signature _____

FINANCIAL AGREEMENT

Our commitment is to provide quality dental care to our patients through exceptional service and the utilization of advanced technology.

Methods of Payment: Cash, Check, MasterCard, Visa, Discover, Insurance.

Insurance: We are happy to accept most forms of insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. **As a courtesy to you, we will file your insurance and accept assignment of benefits. We ask that your estimated co-payment and deductible be paid at the time of service. Not all services are a covered benefit in all contracts.**

Hereforth:

1. I agree to pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family or to the patient.
2. If the balance is not paid within 25 days of the monthly billing date, a late charge of 1.5% on the outstanding balance may be assessed each month.
3. An Administration Fee of $25 will be applied to all returned checks.

Furthermore:

I hereby authorize payment of my insurance benefits directly to the office of Restoration Dental Center. I realize that I am financially responsible for all charges regardless of insurance coverage. I agree to bear administration and late fees as outlined above. I further agree to pay any costs incurred by Restoration Dental Center to effect collection on this account, including reasonable attorney fees.

Insured or Guardian's Signature _____ Patient's Signature _____

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Name:_____ Age:_____ Date:_____

Reason for visit:_____ Referring dentist:_____

To Our Patients: Although dentists 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 are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Current medical conditions:

Current medications:

Weight:_____

PREMEDICATIONS: Y○ N○
Please list:_____

DRUG ALLERGIES: Y○ N○
Please list:_____

LATEX ALLERGY: Y○ N○

PREVIOUS SURGERY: Y○ N○
Please list:_____

Problems with anesthesia: Y○ N○

GENERAL HEALTH

Have you had or do you currently have any of the following?

	Yes	No	Notes		Yes	No	Notes
Anemia				High blood pressure			
Anesthetic problems (family history)				History of drug/alcohol abuse			
Arthritis				Infection			
Asthma				Irregular heart beat			
Bleeding tendency				Jaundice, hepatitis, liver disease			
Blood transfusion				Kidney trouble			
Bronchitis or chronic cough				Low blood pressure			
Cancer				Low blood sugar			
Cardiac pacemaker				Malignant hyperthermia			
Chemotherapy or radiation				Mental health problems			
Contact lenses				Mitral valve prolapse			
Contagious diseases				Pregnancy/nursing			
Convulsions				(estimated due date)			
Delay in healing				Problems with immune system			
Diabetes				Prosthetic knee/hip, etc.			
Dialysis				Radiation treatment for cancer			
Difficulty breathing				Removable dental appliance			
Emphysema				Rheumatic fever			
Epilepsy				Smoker			
Eye disease				Sores in mouth			
Fainting spells				Stomach ulcers			
Gallbladder trouble				Stroke			
Hay fever/sinus problems				Swollen ankles			
Heart attack/chest pains				Thyroid trouble			
Heart disease (family history)				TMJ pain or clicking of jaw			
Heart murmur/artificial valves				Tuberculosis			
Heart surgery				Tumor or growth			

Comments:_____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for errors or omissions that I have made in the completion of this form.

_____ _____ _____

Signature of patient/legal guardian date Dr.'s initials