

### NEW PATIENT REGISTRATION

#### Welcome!

Thank you for choosing us.

We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient, and cost effective manner possible. The more we know about you, the better we can help you.

Please complete these registration forms to the best of your knowledge.

#### PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
First Middle Last

Preferred Name \_\_\_\_\_

Which of the following describes your current status?

Single     Married     Separated

Divorced     Widowed     Minor

SSN \_\_\_\_-\_\_\_\_-\_\_\_\_    **DOB** \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_ Zip \_\_\_\_\_

Phone (home) (\_\_\_\_) \_\_\_\_\_

Phone (cell) (\_\_\_\_) \_\_\_\_\_

Phone (work) (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Position \_\_\_\_\_

Responsible Party \_\_\_\_\_

Responsible SSN \_\_\_\_\_

Method of Payment

Insurance     Cash     Credit Card

CareCredit     Check

Parent/guardian's name if patient is a minor:  
\_\_\_\_\_

Other family members who are patients here:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### DENTAL INSURANCE 1<sup>st</sup> COVERAGE

Employee Name \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_ Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_

#### DENTAL INSURANCE 2<sup>nd</sup> COVERAGE

Employee Name \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_ Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_

**In case of an emergency, please notify** (Name/Phone)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Whom may we thank for this referral?  
\_\_\_\_\_  
\_\_\_\_\_

**Would you like to receive appointment reminders by Phone / Text / Email (please circle one).**

## FINANCIAL RESPONSIBILITY

Dr. Castle and all of his staff are committed to giving you superior dental care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following and let us know if you have any questions.

The insurance company contract is between you, your employer or whoever pays for the plan, and the insurance company. We will bill your insurance plan and do all that we can to help you obtain the maximum benefit from your insurance company, but the responsibility of payment will remain with you. In order for us to bill your insurance company, you must provide us with complete information about your plan, including any necessary forms, group numbers, phone numbers, and addresses.

Most dental insurance plans do NOT cover 100% of your treatment cost. Patients are expected to pay the estimated non-covered portion at the time of service. If your insurance company has not paid within 90 days of treatment, you will need to pay this account in full to this office. We will then reimburse you if and when your insurance company pays. This office can make no guarantees of the insurance plan's estimate of payment. This office does not absolve the patient of responsibility for the charges in full for treatment provided.

Patients who do not participate in an insurance plan are expected to pay for services at the time of delivery.

We accept: Visa, MasterCard, American Express, Discover, Cash, Check, and CareCredit.

All accounts over 60 days will be assessed a 1.5% interest charge per month (18% APR).

Delinquent accounts will be referred to a collection agency at the discretion of the office manager. If your account is turned over to a collection agency, an additional charge of \$75 will be added to cover collection costs.

There will be a \$25.00 fee for all returned checks.

You must give us at least **48 hours notice** if you are unable to make your appointment. **Failure to provide at least 48 hours notice will result in a \$50.00 fee that will be added to your account and must be paid prior to any further treatments.**

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Randy Allen Castle DMD, PC to submit claims to my insurance carrier for all services rendered. I direct third party payers (insurance companies) to issue payment directly to Randy Allen Castle DMD, PC.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

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Print full name (Patient or responsible person if patient is a minor)

Date of Birth

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Signature

Date

## ADULT MEDICAL HISTORY

	DOCTOR'S NOTES
1. Your physician's name _____ Phone _____ Address _____	
2. Have you ever had a serious illness or operation?.....	YES NO
3. When was your last complete physical exam? _____	
4. Are you currently being treated/monitored for a specific condition by your physician?.....	YES NO
5. Are you taking any medication, including birth control?.....	YES NO
6. Do you have any known allergies?.....	YES NO
7. Are you allergic to any specific medications or substances?.....	YES NO
8. Do you have any problem with penicillin, antibiotics, or anesthetics?.....	YES NO
9. Have you been treated for or have you been told you might have heart disease?.....	YES NO
10. Have you ever had a stroke?.....	YES NO
11. Do you have a pacemaker or an artificial heart valve?.....	YES NO
12. Are you aware of any heart problems as a child?.....	YES NO
13. Have you ever had rheumatic fever?.....	YES NO
14. Have you ever been advised to be premedicated with antibiotics prior to dental treatment?.....	YES NO
15. Have you ever had surgery, radiation treatment, or chemo therapy treatment for a tumor, growth, or other condition?.....	YES NO
16. Do you have high or low blood pressure?.....	YES NO
17. Do you have inflammatory diseases, such as arthritis, rheumatism, or lupus?.....	YES NO
18. Do you have any artificial joints or prosthesis?.....	YES NO
19. Do you have any blood disorders, such as anemia, leukemia, etc.?.....	YES NO
20. Have you ever bled excessively after being cut or injured?.....	YES NO
21. Do you have any stomach problems?.....	YES NO
22. Do you have any kidney problems?.....	YES NO
23. Do you have any liver problems?.....	YES NO
24. Are you diabetic, or borderline diabetic?.....	YES NO
25. Do you have asthma?.....	YES NO
26. Do you have epilepsy or seizure disorders?.....	YES NO
27. Do you have AIDS or have you tested positive for HIV?.....	YES NO
28. Have you ever had hepatitis?.....	YES NO
29. Have you ever had a blood transfusion?.....	YES NO
30. Have you ever had tuberculosis?.....	YES NO
31. Do you use any tobacco products?.....	YES NO
32. Do you consume alcoholic beverages?.....	YES NO
33. Are you pregnant or suspect that you may be?.....	YES NO
34. Do you have any disease, condition, or problem not listed?.....	YES NO
35. Is there anything else we should know about your health that we have not covered?.....	YES NO
36. Would you like to speak to the Doctor privately about any concerns?....	YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

## PAST DENTAL HISTORY

		DOCTORS NOTES
1. Purpose of initial visit? _____		
2. Are you aware of any dental problems?.....	YES NO	
If yes, please explain _____		
3. How long since your last dental visit? _____		
4. What was done at that time? _____		
5. What is your previous dentist's name? _____		
6. Have you made regular visits to a dentist?.....	YES NO	
How often? _____		
7. Were dental x-rays taken at your last dental appointment?.....	YES NO	
8. Have you lost any teeth?.....	YES NO	
Why? _____		
9. Have any lost teeth been replaced?.....	YES NO	
10. Are you happy with the replacement(s)?.....	YES NO	
11. Have you ever had any problems with previous dental treatment?.....	YES NO	
12. Do you clench or grind your teeth?.....	YES NO	
13. Does your jaw click or pop?.....	YES NO	
14. Do you have pain or soreness in the muscles of your face or around your ears?.....	YES NO	
15. Do you have frequent headaches, neck aches, or shoulder aches?.....	YES NO	
16. Does food get caught between your teeth?.....	YES NO	
17. Circle any of the following that your teeth are sensitive to: Hot      Cold      Sweets      Pressure/Biting		
18. Do your gums bleed or hurt?.....	YES NO	
19. How often and when do you brush your teeth? _____		
20. Do you use dental floss?.....	YES NO	
How often? _____		
21. Are any of your teeth loose, tipped, or shifted?.....	YES NO	
22. Do you have any discolored teeth that bother you?.....	YES NO	
23. Do you feel your breath is offensive at times?.....	YES NO	
24. Have you ever had gum treatment or surgery?.....	YES NO	
25. Do you feel good about your teeth in general?.....	YES NO	
26. Are you happy with the appearance of your teeth?.....	YES NO	
27. Have you had any unpleasant dental experiences?.....	YES NO	
28. List anything about dentistry that you strongly dislike: _____ _____		
29. Do you have any dental questions or concerns?.....	YES NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date