elite dentistry
lasting impressions

New Patient Registration
Personal Details

Ruth Clemans D.D.S.
COSMETIC, GENERAL & SEDATION DENTISTRY

Patient's Name: **Preferred Name:**

Address: City: State: Zip Code:

Home Phone: Bus. Phone: Ext #:

Cell Phone: eMail Address:

Social Security No: Drivers License No:

Date of Birth: Sex: Male Female Marital Status:

Patient's Occupation: Employer:

Business Address: City: State: Zip Code:

Spouse's Name:

Spouse's Occupation: Employer:

Spouse's Bus. Address: City: State: Zip Code:

Spouse's Bus. Phone: Extension:

Spouse's Cell #:

Children (Names & Birth Dates):

Patient's Special Interests:

If Patient is a Minor: Age: School Attending: Grade:

Mother's Name

Mother's Address:

Father's Name:

Father's Address:

I hereby authorize Ruth H. Clemans D.D.S. to treat the above named child and I accept responsibility for payment in full. I further authorize Dr. Ruth Clemans, any employee or agent of Elite Dentistry to take any necessary radiographs for diagnosis and treatment purposes. Similarly, I authorize the same employees or agents of Elite Dentistry to administer fluoride at recare visits.

Guardian's Signature Date Relationship to Patient

Person Financially Responsible for Accounts:

Name: Birth Date: SSN:

Phone #'s: Work: Home: Cell:

eMail Address:

Address:

Drivers License No: Relationship to Patient:

Please indicate how you would prefer to pay: CASH PERSONAL CHECK MASTER/VISA CARD

Payment is due in full at the time of the appointment unless prior arrangements have been made in writing.

Do you have the benefit of Dental YES NO

To help our patients maximize their dental dollars in affording their dental health care, we may accept assignment of insurance benefits. The balance for treatment you or your family receive is due at the time of service. To assist you in filing your insurance we will need your complete insurance details. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid on your claim within 45 days, the full balance will automatically transfer to you and be immediately payable.

Please initial to acknowledge notice that Dr. Clemans and Elite Dentistry are not Medicare providers and does not accept Medicare fees or benefits at this office.

For insurance purposes please sign below:

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment:

Signed (Patient or Guardian if Patient a Minor.) Date

Person to contact in case of emergency:

Name: Phone No:

Address: City: State: Zip Code:

Closest relative not living with you:

Name: Phone No:

Address: City: State: Zip Code:

Next page for Health History........

elite dentistry — lasting impressions

New Patient Registration
Page 2 - Health Details

Ruth Clemans D.D.S. — COSMETIC, GENERAL & SEDATION DENTISTRY

Reason for today's visit: ____________

Who may we thank for referring you: ____________

Have you been hospitalized during the last two years: YES / NO Reason: ____________

In the last 2 yrs, have you been under the care of a doctor: YES / NO Reason: ____________

Physician's Name: ____________ Physician's Phone #: ____________

Physician's Address: ____________

Are you currently taking any medication: YES / NO — If YES, please indicate the type, dose, frequency and reason it is being taken.

____

Are you ALLERGIC to, or have you ever reacted adversely to any medication or substance: YES / NO — If YES, please detail on next line:

____

Indicate which of the following you have had or have at present? Cross (X) "**Y**" for YES or "**N**" for "NO" to each item. Cross "**Y**" and "**P**" if you have at present:

Condition		Condition		Condition	
Heart Failure:...	Y / P / N	Drug Addiction:...	Y / P / N	Hepatitis A (Infectious):...	Y / P / N
Heart Disease or Attack:...	Y / P / N	Stroke:...	Y / P / N	Hepatitis B (Serum):...	Y / P / N
Angina Pectoris:...	Y / P / N	Artificial Joints:...	Y / P / N	Hepatitis C:...	Y / P / N
Congenital Heart Disease:...	Y / P / N	Kidney Trouble:...	Y / P / N	Venereal Disease:...	Y / P / N
Heart Murmur:...	Y / P / N	Ulcers:...	Y / P / N	AIDS or HIV positive:...	Y / P / N
High Blood Pressure:...	Y / P / N	Diabetes:...	Y / P / N	Cold Sores / Fever Blisters:...	Y / P / N
Arteriosclerosis:...	Y / P / N	Thyroid Problems:...	Y / P / N	Blood Transfusion:...	Y / P / N
Mitral Valve Prolapse:...	Y / P / N	Glaucoma - Narrow/Wide:...	Y / P / N	Hemophilia:...	Y / P / N
Artificial Heart Valve:...	Y / P / N	Cosmetic Surgery:...	Y / P / N	Anemia:...	Y / P / N
Defibrillator / Pacemaker:...	Y / P / N	Emphysema:...	Y / P / N	Liver Disease:...	Y / P / N
Heart Surgery:...	Y / P / N	Tuberculosis:...	Y / P / N	Epilepsy or Seizures:...	Y / P / N
Rheumatic Fever:...	Y / P / N	Asthma:...	Y / P / N	Fainting or Dizzy Spells:...	Y / P / N
Arthritis:...	Y / P / N	Allergies or Hives:...	Y / P / N	Nervousness:...	Y / P / N
Rheumatism:...	Y / P / N	Radiation Therapy:...	Y / P / N	Psychiatric Treatment:...	Y / P / N
Cortisone Medicine:...	Y / P / N	Chemotherapy:...	Y / P / N		Y / P / N
Osteonecrosis of the Jaw:...	Y / P / N	Taken Bisphosphonate Meds:...	Y / P / N		Y / P / N

Have you ever been diagnosed with cancer or a tumor: YES / NO Details ____________

Do you use any tobacco based products: YES / NO Are you interested in quitting: YES / NO

If "YES" above, Indicate daily quantity: ____________ What do you use: ____________

Do you have any problems with: SNORING DAYTIME SLEEPINESS or APNEA Are you allergic to latex: YES / NO

Do you have, or have you had, any disease, condition or problems not listed: If "yes" please detail here: ____________

____

WOMEN ONLY: Are you Pregnant: YES / NO Are you Nursing: YES / NO Do you use Birth Control Pills YES / NO

CONSENT

I understand that the above information is necessary to provide me with Dental Care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I, the undersigned, hereby authorizes Dr Ruth H Clemans *(the "**Doctor**")*, Elite Dentistry and/or any employee or agent of Dr Ruth H Clemans and/or Elite Dentistry, *(hereinafter collectively referred to as the "**Practice**")* to take radiographs, study models, photographs, or use any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my, or my dependent's, dental needs. I also authorize the Practice to perform any and all forms of treatment, medication or therapy that may be indicated with the above named patient and further authorize and consent that the Doctor may choose and employ such assistants as deemed appropriate.

I understand the use of anesthetic agents embodies a certain risk including, but not limited to transient or permanent numbness.
I understand and authorize the use of any of my, or my dependent's photographs, radiographs or models for educational, demonstrational or promotional use.

I understand that the responsibility for payment for Dental Services provided by the Practice, in their office, for myself and/or my dependents, is mine, and that payment is due and payable at the time services are rendered; unless prior financial arrangements have been made and agreed upon, in writing. I further understand that a one and a half percent (1.5%) finance charge per month (18% per annum) will be added to any balance outstanding over forty-five (45) days. In the event of default, I/We promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

In the unlikely event that I, the patient, or the guardian of a patient, has a dispute with the Doctor or the Practice, I hereby agree that the dispute shall be settled by arbitration.
By signing this consent form, I agree to be bound by its terms and acknowledge that I understand the meaning of each clause. I state that I am authorized and have the capacity to enter into this agreement. All my questions have been satisfactorily answered.

____________ ____ / ____ / 20____ ____________

Patient Date Witness

Responsible Party for Patient: ____________ Relationship: ____________

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Please Handle Me with Care

Put a check mark in the box next to the statement that concerns you or describes your problem. Then share this information with our dental team.

- ☐ **I gag easily.**
- ☐ **I feel out of control when I'm lying down in the dental chair.**
- ☐ **I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.**
- ☐ **Pain relief is a top priority for me.**
- ☐ **I don't like shots (or I've had a bad reaction to shots).**
- ☐ **Please tell me what I need to know about my mouth in order to make an informed decision.**
- ☐ **My teeth are very sensitive.**
- ☐ **I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.**
- ☐ **I don't like cotton in my mouth.**
- ☐ **I hate the noise of the drill.**
- ☐ **Please respect my time. I don't want to be left sitting in the reception area.**
- ☐ **I want to know the cost up front. No money surprises please.**
- ☐ **I have difficulty listening and remembering what I hear while sitting in the dental chair.**
- ☐ **I have health problems and questions that we need to discuss.**

A "Handle Me with Care" Partnership

Now that you understand the importance of communicating all your fears and any issues of embarrassment and trust, let's look at making a "handle me with care" pact between you and your dental professionals. This simple, straightforward statement will make a big difference in how you are treated and how you feel about going to the dentist.

THE HANDLE ME WITH CARE PARTNERSHIP PACT:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

Date: ______________________ Name: ______________________

DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us better serve you.

	Yes	No
Are you having any discomfort?	☐	☐
Sensitivity to hot, cold, sweets, chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐
Have you experienced any of the following problems:		
Bleeding Gums	☐	☐
Bad Breath	☐	☐
Soreness in jaw joint	☐	☐
Grinding/Clenching of teeth	☐	☐
Snoring	☐	☐
Sleep problems	☐	☐
Frequent headaches	☐	☐
Do you think your dental health affects your overall health?	☐	☐
Do you think it is important to have your teeth cleaned every six months?	☐	☐
Do you smoke or use tobacco in any form?	☐	☐
Do you drink coffee, tea, or red wine?	☐	☐
Are you interested in the prevention/treatment of bad breath?	☐	☐

On a scale of 1 to 10 with 10 being the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

	Yes	No
Is the brightness of your teeth important to you?	☐	☐
If I could change my smile I would make my teeth:	☐	☐
Whiter	☐	☐
Straighter	☐	☐
Close space	☐	☐
Replace Black Mercury fillings with tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Less gum showing	☐	☐
Replace old crowns or caps that don't match	☐	☐
Do you prefer to save your teeth?	☐	☐
Have you ever had a special coating applied to your back teeth to protect from tooth decay?	☐	☐
Do you take a fluoride supplement?	☐	☐
Do you having any habits:		
Biting cheeks/lips	☐	☐
Biting fingernails	☐	☐
Chewing ice	☐	☐
biting pencils/pens	☐	☐
Are you a mouth breather (versus a nose breather)?	☐	☐
Have you ever been told that you have gum disease?	☐	☐
Does anyone in your immediate family have gum disease?	☐	☐
Did you ever wear braces?	☐	☐
If Yes, do you still wear a retainer?	☐	☐

Have you (even as a child) experienced any trauma to your adult teeth? If Yes, please explain______________________

____

When was the last time you had an oral cancer exam?______________ Date of last cleaning?______________

If there were a way to whiten your teeth for a very reasonable investment, would you be interested?______________

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?______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
Please Print Name

____
Signature

____
Date

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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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