PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Patient's First Name:	Middle Initial:	Last Name:	Gender: ❑ Male ❑ Female	Social Security Number:	Birth Date: / /
Street Address:		City:	State:		Zip Code:
Mailing Address: ❑ Same as above			Home Phone Number where messages can be left: ( )		
Email Address:			Cell Phone Number where messages can be left: ( )		
Email Reminders: ___ yes ___ no			Text Reminders: ___ yes ___ no		
Preferred Pharmacy:					

PARENT/LEGAL GUARDIAN/SPOUSE INFORMATION		
Name:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Spouse ❑ Guardian (Specify): _____
Name:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Spouse ❑ Guardian (Specify): _____

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN		
Name:	Phone Number:	Relationship to Patient :
Name:	Phone Number:	Relationship to Patient :

INSURANCE INFORMATION

Please present ALL insurance cards to the front desk

Medical Insurance: _____

Subscriber Name (if different than the patient): _____ *Relationship to Patient:* ❑ *Spouse* ❑ *Parent* ❑ *Step Parent*

Subscriber's Birthdate: _____ *Subscriber's Social Security Number:* _____

Subscriber's Phone Number: _____ *Subscriber's address:* _____

Dental Insurance: _____

Subscriber Name (if different than the patient): _____ *Relationship to Patient:* ❑ *Spouse* ❑ *Parent* ❑ *Step Parent*

Subscriber's Birthdate: _____ *Subscriber's Social Security Number:* _____

Subscriber's Phone Number: _____ *Subscriber's address:* _____

PROTECTED HEALTH INFORMATION Person(s) who may obtain my medical and/or dental health information. This may include verbal and/or copies of records unless specified by you.		
Name:	Phone Number:	Relationship type:
Name:	Phone Number:	Relationship type:

Consent to Treat
By signing below I am giving consent for myself/my ward to receive any treatment as deemed necessary by the attending health
care provider. By signing below I also consent to treatment for myself/my ward by Tiger Family Dental providers and/or students from school of dentistry when or if dental services are provided.

Initial: _____

Receipt of Privacy Statement:
We are committed to protecting your personal health information in compliance with the law. By signing below you are acknowledging that you have read and agree with the Tiger Family Dental privacy statement and understand that at any time upon request, you may obtain a copy of the Tiger Family Dental Statement of Privacy Practices
Initial: _____

Patient Rights

- ☑ Receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, or communicable disease.
- ☑ Personal Provider – each patient has an ongoing relationship with a primary care provider (PCP) who will give complete and continuous care.
- ☑ Comprehensive Dental Care - You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, risks, benefits, side effects.
- ☑ Provider Directed Dental Practice - the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your dental PCP, hygienist, dental assistant, and expanded functions dental assistant.** The care team will support the patient for self-management of their oral health and oral health care goals.
- ☑ Privacy – You have the right to the privacy and confidentiality of all your records pertaining to your treatment, except as required by law or third party payment. Your dental record can be read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation. You have the right to access the information contained in your record, within the limit of the law and facility policy. Please refer to the Tiger Family Dental Notice of Privacy for additional information on your privacy rights.

Financial Guideline

We at Tiger Family Dental are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Guidelines, or your responsibility.

- **All patients must complete our "Patient Registration Forms" before seeing the dental professional.**
- **Full payment is due at time of service.**
- **We accept Cash, Check, American Express, Visa, Mastercard, Discover, Care Credit, Apple Pay, and Samsung Pay.**

Insurance

Tiger Family Dental bills insurance as a courtesy to our patients. The patients portion of dental service(s) is estimated and due at time of service. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount. Tiger Family Dental will help you with any insurance questions that you may have.

The claims we submit to insurance companies indicate that you have assigned those benefits to Tiger Family Dental. However, if you are paid by the insurance company instead of Tiger Family Dental, you then become responsible for the total balance and payment would be expected immediately.

You as the patient are always responsible for any charges that are not covered by your insurance company.

Delinquent Payments

All payments returned due to non-sufficient funds will be subject to NSF of $35.

Cancellations

We want to create an environment where there is a mutual respect between our patients and our team to honor the time and commitment on both parties. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen for needed treatment. We ask that you please give us at least 24 hours notice to any changes or cancellations to your appointment. If prior notice is not given there is a $45 fee associated with the canceled or missed appointment.

Thank you for your understanding and agreement to our financial guidelines. Please let us know if you have any questions or concerns.

Patients signature: _____ **Date:** _____

Medical History Form

Date:

Patients Name: Birth Date:

Who is your Medical doctor?

Have you ever had a serious head or neck injury? Y/N

Do you use tobacco (including e-cigs)? Y/N

Do you use controlled substances? Y/N Do you consume alcohol? Y/N

Do you snore or have you been told that you snore? Y/N Do you wear a C-PAP or have you been told to? Y/N

Have you been hospitalized or had a major operations? Y/N

Women: Are you..

Pregnant? Y/N Trying to get pregnant? Y/N Taking oral contraceptives? Y/N Nursing? Y/N

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Latex	☐ Sulfa drugs	☐ Local anesthetics	☐ Valium	

Other allergies?

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Are you taking medications? Please list

Do you have ever been diagnosed with, or treated for any of the following? (Check all that apply)

☐ Abnormal bleeding	☐ COPD	☐ Low blood pressure
☐ Acid Reflux	☐ Diabetes	☐ Lupus
☐ AIDS/HIV	☐ Epilepsy	☐ Osteoporosis
☐ Alzheimer's disease	☐ Fibromyalgia	☐ PTSD
☐ Anemia	☐ Glaucoma	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Heart attack	☐ Shortness of breath
☐ Artificial bones/joints	☐ Hemophilia	☐ Sleep apnea
☐ Artificial heart valves	☐ Hepatitis A/B/C	☐ Tuberculosis
☐ Asthma	☐ High blood pressure	
☐ Cancer	☐ High cholesterol	
☐ Congenital heart defects	☐ Kidney disease	

Signature:

Dental History Form

Reason for today's visit: _____

Are you in pain? Y/N

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? Y/N

Do you have Bitewing x-rays that are less than 1 year old? Y/N

Name of former dentist: _____

City/State: _____

Date of last cleaning and exam: _____

Do you take Bisphosphonates? _____

Do you have any of the following habits?

☐ Cheek biting ☐ Nail biting ☐ Eating disorder ☐ Sleep apnea ☐ Substance abuse
☐ Gum chewing ☐ Tongue thrusting ☐ Mouth breathing ☐ Teeth grinding/clenching
☐ Thumb/finger sucking ☐ Tooth picking

Please provide more information about your dental history below:
Are you happy with your smile? Y/N
Are you nervous about having dental treatment? Y/N
Are you having any pain or discomfort at this time? Y/N
Are your teeth sensitive to heat, cold, or anything else? Y/N
Do you have an electric toothbrushes? Y/N
Do you have difficulty or pain when opening your mouth wide? Y/N
Do you currently have an orthotic for your teeth? Y/N Bite splint, Night guard
Do you have pain in the area from your temple to your ears? Y/N
Do your gums bleed whe you brush? Y/N
Does your jaw pop and/or click? Y/N
Have you ever had adverse reaction to dental anesthetic? Y/N
Have you ever had difficulty getting numb? Y/N
Have you had treatment for a jaw joint pain? Y/N
Have you had braces? Y/N

24 hour Cancellation Policy

****Please read carefully and sign****

Tiger Family Dental is committed to providing exceptional care to our patients! We want to create an environment where there is a mutual respect between our patients and our team to honor the time and commitment on both parts. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen for needed treatment. We ask that you please give us at least 24 hours' notice to any changes or cancellations to your appointment. If prior notification is not given, you will be charged $45.00 for the missed appointment.

By signing below, you acknowledge that you have read and understand the cancellation policy for Jonathan R. Ehlers D.D.S. P.C., as described above.

X_____ Date:_____