Patient ID (office use only): _____
Patient Initial: _____ Date: _____

GREAT SMILES DENTAL CARE
610 Professional Dr., Suite 250 • Gaithersburg, MD 20879
Tel: (301) 963-5555 • Fax: (301) 963-8072
www.GreatSmilesDentalCare.com
info@GreatSmilesDentalCare.com

PATIENT REGISTRATION FORM

Great Smiles Dental Care takes your oral health very seriously.
To help us meet all your healthcare needs, please fill out this form completely in ink.

PATIENT INFORMATION

Name (Last, First, M.I.): _____ SSN: _____ DOB: _____

Gender: ☐ Male ☐ Female Marital Status (circle one): minor / single / married / other _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Email Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse Name: _____ Spouse's Occupation: _____

To whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____ Relation to patient: _____

RESPONSIBLE PARTY (If Different from patient)

Name (Last, First, M.I.): _____ SSN: _____ DOB: _____

Relation to Patient: _____ Home Phone: _____ Cell Phone: _____

Home Address (if different from patient's): _____

Employer: _____ Phone: _____ Occupation: _____

Employer's Address: _____

INSURANCE INFORMATION

Insured's Name (Last, First, M.I.): _____ SSN: _____ DOB: _____

Relation to Patient: _____ Home Phone: _____ Cell Phone: _____

Insured's Employer: _____ Employer Phone: _____

Insurance Company Name: _____ Subscriber #: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Additional Insurance:

Insured's Name (Last, First, M.I.): _____ SSN: _____ DOB: _____

Relation to Patient: _____ Home Phone: _____ Cell Phone: _____

Insured's Employer: _____ Employer Phone: _____

Insurance Company Name: _____ Subscriber #: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone: _____

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MEDICAL HISTORY

Although dental personnel primarily 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 may be taking, could have an important interrelationship with the dentistry you will receive. Please take time and fill out this section. Thank you.

Do you have general health problem? ☐ Yes ☐ No Please specify: _____

Are you currently under physician's care? ☐ Yes ☐ No If yes, please explain: _____

_____

Name of physician: _____ Phone: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Are you on a special diet? ..... ☐ Yes ☐ No

Do you use tobacco? ..... ☐ Yes ☐ No

Do you use controlled substances? ..... ☐ Yes ☐ No

Are you currently taking any drugs or medications? ☐ Yes ☐ No Please list: _____

_____

Are you allergic to: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal

☐ Local Anesthetics ☐ Other, please explain _____

_____

If female, are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Do you have, or have you had, any of the following?

Yes/No		Yes/No		Yes/No	
☐	☐ AIDS/HIV Positive	☐	☐ Excessive Bleeding	☐	☐ Lung Disease
☐	☐ Alzheimer's Disease	☐	☐ Excessive Thirst	☐	☐ Mitral Valve Prolapse
☐	☐ Anaphylaxis	☐	☐ Fainting Spells/Dizziness	☐	☐ Pain in Jaw Joints
☐	☐ Anemia	☐	☐ Frequent Cough	☐	☐ Parathyroid Disease
☐	☐ Angina	☐	☐ Frequent Diarrhea	☐	☐ Psychiatric Care
☐	☐ Arthritis/Gout	☐	☐ Frequent Headaches	☐	☐ Radiation Treatments
☐	☐ Artificial Heart Valve	☐	☐ Genital Herpes	☐	☐ Recent Weight Loss
☐	☐ Artificial Joint	☐	☐ Glaucoma	☐	☐ Renal Dialysis
☐	☐ Asthma	☐	☐ Hay Fever	☐	☐ Rheumatic Fever
☐	☐ Blood Disease	☐	☐ Heart Attack/Failure	☐	☐ Rheumatism
☐	☐ Blood Transfusion	☐	☐ Heart Murmur	☐	☐ Scarlet Fever
☐	☐ Breathing Problem	☐	☐ Heart Pace Maker	☐	☐ Shingles
☐	☐ Bruise Easily	☐	☐ Heart Trouble/Disease	☐	☐ Sickle Cell Disease
☐	☐ Cancer	☐	☐ Hemophilia	☐	☐ Sinus Trouble
☐	☐ Chemotherapy	☐	☐ Hepatitis A	☐	☐ Spina Bifida
☐	☐ Chest Pains	☐	☐ Hepatitis B or C	☐	☐ Stomach/Intestinal Disease
☐	☐ Cold Sores/Fever Blisters	☐	☐ Herpes	☐	☐ Stroke
☐	☐ Congenital Heart Disorder	☐	☐ High Blood Pressure	☐	☐ Swelling of Limbs
☐	☐ Convulsions	☐	☐ Hives or Rash	☐	☐ Thyroid Disease
☐	☐ Cortisone Medicine	☐	☐ Hypoglycemia	☐	☐ Tonsillitis
☐	☐ Diabetes	☐	☐ Irregular Heartbeat	☐	☐ Tuberculosis
☐	☐ Drug Addiction	☐	☐ Kidney Problems	☐	☐ Tumors or Growths
☐	☐ Easily Winded	☐	☐ Leukemia	☐	☐ Ulcers
☐	☐ Emphysema	☐	☐ Liver Disease	☐	☐ Venereal Disease
☐	☐ Epilepsy or Seizures	☐	☐ Low Blood Pressure	☐	☐ Yellow Jaundice

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DENTAL HISTORY

Name of Previous Dentist _____ Location & Phone _____

Date & Procedure Done by Previous Dentist _____

What prompted you to seek dental care at this time?_____

Why did you leave your previous dentist? _____

	Yes / No
• Do your gums bleed while brushing or flossing?	☐ ☐
• Are your teeth sensitive to hot or cold?	☐ ☐
• Are your teeth sensitive to sweet or sour?	☐ ☐
• Are you teeth sensitive to biting pressure?	☐ ☐
• Do you feel pain to any of your teeth?	☐ ☐
• Does food constantly get stuck between certain teeth in your mouth?	☐ ☐
• Have you had any head, neck or jaw injuries?	☐ ☐
• Have you ever experienced any of the following problems in your jaw?	
- Clicking	☐ ☐
- Pain (joint, ear, side of face).....	☐ ☐
- Difficulty in opening or closing	☐ ☐
- Difficulty in chewing	☐ ☐

	Yes / No
• Do you have frequent headaches?	☐ ☐
• Do you clench or grind your teeth?	☐ ☐
• Do you bite you lips or cheeks frequently?	☐ ☐
• Have you ever had any difficult extractions?	☐ ☐
• Have you ever had any prolonged bleeding following extractions?	☐ ☐
• Have you had any orthodontic treatment?	☐ ☐
• Do you wear dentures or partials?	☐ ☐
If yes, date of placement _____	
• Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ ☐
• Are you dissatisfied with your smile in any way?	☐ ☐
• Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc	☐ ☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that it is my responsibility to inform Great Smiles Dental Care of any changes in medical status.

X _____ _____
Signature of patient (or parent/guardian if minor) Date

Patient ID (office use only): _____

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PHOTO AND DIGTAL IMAGES CONSENT

Dear Patient:

Occasionally, we are taking pictures of your teeth, smile or of entire face. We are using them (or just keeping them on file) for Insurance and for Liability reasons. Some of the dental cases are unique and some of them are very helpful for other patients to make a decision regarding dental treatment. We do not sign your name under the images and we use them for internal office purposes only.

By signing this form, I agree to give Great Smiles Dental Care, its associates and dental assistants permission to take and to use free of charge, photos and digital images of me and of my dental work for internal office use, website and for educational purposes. I understand that I may revoke permission to use my photographs / images at anytime by contacting Great Smiles Dental Care in writing.

Name (Last, First, M.I.): _____
(Patient/Subscriber or Guardian if a minor)

_____ _____
Signature Date

Patient ID (office use only): _____
Patient Initial: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

(Health Insurance & Accountability Act of 1996)

Great Smiles Dental Care takes your oral health very seriously.
To help us meet all your healthcare needs, please fill out this form completely in ink.

PATIENT ACKNOWLEDGEMENT

Patient name (Last, First, M.I.): _____

_____

Thank you for taking the time to review our Notice of Privacy Practice. If you have any questions, we want to hear from you. If you do not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this acknowledgement to our office at the address indicated above.

_____ _____

Patient/Guardian Signature Date

You reserve the right to request your information not to be released to

_____

For example: *Do not bill my insurance. Do not release my information to my spouse*

Please check one: ☐ Please provide me with a copy
☐ I do not require a copy

Great Smiles Dental Care
HIPAA Privacy Officer

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 (specify) _____

_____

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PATIENT AGREEMENT

Insurance contract is an agreement between you and your insurance company. Therefore it is important that you fully understand your benefits as well as restrictions including but not limited to yearly deductibles, maximum coverage, co-Payments. We honor your insurance fees and will help you file for the service rendered.

We will give you a best ESTIMATE cost of your portion and it must be paid at the time of your treatment. Any outstanding balances not covered by your insurance will be billed to you at a later time.

FINANCIAL CHARGES: All returned checks are subject to $25 fee. All balances over 60 days are subject to interest in amount of applicable by State law. We reserve the right to apply $20 rebilling fee and $25.00 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau.

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.
_____(Initialize)

MISSED APPOINTMENT FEE: Please note that there is a missed appointment fee of $45.00 per half an hour for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment. _____ (Initialize)

TRANSFERRING RECORDS: You will need to request in writing if you would like us to mail, fax, e-mail, etc. any part of your records with Great Smiles Dental Care.

By signing below, you acknowledge that you are responsible for the fees incurred and release us from any obligations regarding your insurance limitations.

Name (Last, First, M.I.): _____
(Patient/Subscriber or Guardian if a minor)

_____ _____
Signature Date