PATIENT REGISTRATION

Welcome to TOTAL ARCH DENTAL IMPLANT CENTER

What brings you to TOTAL ARCH? _____

Previous Dentist: _____

How did you hear about us? ☐**Google** ☐**Facebook** ☐**Website** ☐**Radio**

☐**Dr. Referral:**_____ ☐**Friend Referral:**_____

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name (Nickname): _____ Preferred Pharmacy & Phone #: _____

Mailing Address:_____ _____

City:_____ State: _____ Zip:_____

Cellular Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ I would like to receive correspondence via email: Yes/No

Sex: O Female O Male Marital Status: O Married O Single

Birth Date:_____ Age:_____ Social Security: _____-_____-_____

My mouth is: ☐ very comfortable ☐ moderately comfortable ☐ uncomfortable

My smile: ☐ is excellent ☐ needs changes ☐ has no concerns

MY DENTAL HEALTH IS: ☐Excellent ☐Good ☐Fair ☐Poor

☐I want to keep my teeth but only within a certain budget of time and money ☐I am indifferent

☐I will do whatever I must to keep my teeth

Total Arch Dental Implant Center **is not under contract (in network)** with any dental insurance plans, however out of courtesy, we will help in submitting all claims to your individual dental insurance.

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: SELF/SPOUSE/CHILD

Insured Date of Birth: _____ Insurance Co: _____

Insured Soc.Sec: _____ Insurance Co Address: _____

Employer: _____ City, State, Zip: _____

Phone #: _____

Member ID: _____ Group#: _____

Secondary Insurance Information (If Applicable)

Name of Insured: _____ Relationship to Insured: SELF/SPOUSE/CHILD

Insured Soc.Sec: _____ Insured Date of Birth: _____

Employer: _____ Insurance Co: _____

Member ID:_____ Address: _____

Total Arch Dental Implant Center – 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. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Has a physician or previous dentist reccomend that you take antibiotics prior to your dental visit?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X _____

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name (Please Print)

_____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date

GENERAL CONSENT FOR TREATMENT

_____ _____

Patient's Name Today's Date

We are asking you to read and sign the following. It means that you understand the recommended treatment plan or alternative treatment plans that have been presented to you.

An understanding of the risks and benefits of the treatment plan will help you to make a decision as to treatment you wish to pursue. When informed of the risks and benefits of treatment, we feel you will be happier with the final outcome.

This document's purpose is to supplement the treatment plan explanation provided to you by the doctor to assure your understanding of the alternative treatment plans and to document your consent to the recommended treatment plan.

I have received the TOTAL ARCH DENTAL IMPLANT CENTER Notice of Privacy Practices.

_____

(initial)

CONSENT:

I,_____, have been informed by the doctor of the need to undergo dental or oral medicine treatment as presented to me, and the relevant information regarding my treatment has been read by me and explained to me. I have been fully informed about the diagnosis, details and estimated costs of recommended treatment and alternatives. I agree to accept this recommended treatment as present diagnoses dictate at this time.

I understand that as treatment proceeds there may be a need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I have discussed all of the above with my doctor and all of my questions have been answered. I have been informed that success of treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medications, and reporting to my doctor any changes in health status. I acknowledge that the doctor has not made any warranties or guarantees concerning treatment or its long-term success.

ASSIGNMENT OF ACCEPTED INSURANCE BENEFITS:

I, _____, acknowledge that Total Arch Dental Implant Center is not under contract (in network) with any dental insurance plans.

I understand I am responsible for the cost of the procedure in full on the day of the procedure. TOTAL ARCH DENTAL IMPLANT CENTER do accept cash, check, credit card, and care credit.

Out of courtesy, TOTAL ARCH DENTAL IMPLANT CETNER will help in submitting any claims to my individual dental insurance. I give TOTAL ARCH DENTAL IMPLANT CENTER permission to help file insurance claims on my behalf so that I, the patient, may receive maximum benefit from my dental insurance plan.

VALUABLES:

I, _____, take full responsibility for all personnel items and valuables during the time I am at TOTAL ARCH DENTAL IMPLANT CENTER, such as jewelry, money, wallets, cell phones, electronic devices, dentures, etc. TOTAL ARCH DENTAL IMPLANT CENTER accepts no responsibility or liability for the loss or damage of these items. To the fullest extent permitted by law, I agree to release and hold harmless the practice for liability for loss of or damage to my personal items or valuables.

I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

_____	_____	_____
Patient's Name	Patient Signature (Guardian if patient is a minor)	Today's Date

Dr. Michael Weisner	_____	_____
Doctor's Name	Doctor's Signature	Today's Date

_____	_____	_____
Witness' Name	Witness' Signature	Today's Date

ASSIGNMENT OF ACCEPTED INSURANCE BENEFITS
Financial Consent Agreement

TOTAL ARCH DENTAL IMPLANT CENTER is not under contract (in network) with any dental insurance plans.

I understand I am responsible for the cost of the procedure in full on the day of treatment,

_____
(signature)
Date: _____

Out of courtesy, TOTAL ARCH DENTAL IMPLANT CENTER will help in submitting any claims to my individual dental
Benefit plan. I give TOTAL ARCH DENTAL IMPLANT CENTER permission to help file insurance claims on my behalf so that I, the patient, may receive maximum benefit from my dental insurance plan.

Our patients understand that in order to deliver optimum dentistry, we must maintain our office on sound principles. Therefore, we inform our patients of our financial policies at the very beginning of our relationship to avoid any misunderstandings in the future.

We believe that:

1. You should decide the quality of the dental treatment you prefer not an insurance company.
2. Oral health care and the choice of dental materials used should be determined by you and your dentist rather than a dental insurance carrier.
3. Our fees are the same for all patients, however, your dental insurance policy may reimburse you based on their own fee schedule which may or may not coincide with our fees. You should be aware that insurance companies vary greatly in the type of coverage available. Some companies reimburse claims promptly while others may delay payment for several months.

For your convenience, we accept a variety of payment methods that include **check, cash, and all major credit cards. Full payment is REQUIRED at the time your services are performed.**

Financing:

As a courtesy to our patients we offer Care Credit and for extended financing. They have "no interest options" available and are quite easy to deal with. You may apply at home or here in the office. Please ask someone within the office with help in signing up for Care Credit.

Cancellation Policy:

We kindly ask for a 48 hour notice for cancellation of appointments otherwise a charge may be incurred at our discretion.

Consent for Dental Photography

Patient Name:_____ Birth Date:_____

I authorize Total Arch Dental Implant Center to take photographs, and/or videos of my face, jaws, and teeth before, during, and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, and demonstrations
- Marketing material, including web sites and printed materials for patient education

I further understand that if the photographs and/or videos are used, my name, the photo of my face, or other identifying information will be kept confidential.

_____ _____

(Patient Signature) Date