Esthetic Design Dental

New Patient Registration

Welcome to Esthetic Design Dental

At our office, you will find the best dental care from our highly skilled staff using state-of-the-art dental technology. Please complete the form below so we can get to know you.

Name: _____
First Middle Initial Last

Date of Birth: _____ Social Security Number: _____

Name of Responsible Party (if patient is Minor): _____

Address: _____
Street Apt

_____
City State Zip

Phone: _____ _____ _____
Home Work Mobile

What is the best number and time of day to contact you? _____

Driver's License: _____ Email Address: _____

Insurance Information

Name of Insured Person: _____ Insured's Date of Birth: _____

Employer: _____ Name of Insured Company: _____

Group Number: _____ Participant Number: _____
May be Insured's SSN

Secondary Insurance (if any): _____

Emergency Contact Information

Name: _____
First Middle Initial Last Relationship

Phone: _____ _____ _____
Home Work Mobile

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Dental History

Have you had orthodontic treatment? Yes ☐ No ☐

Are you dissatisfied with the appearance of your teeth? Yes ☐ No ☐

Do you clench or grind your teeth at night? Yes ☐ No ☐

Have you ever had pain in your jaw? Yes ☐ No ☐

Do you have an unpleasant taste in your mouth? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐

Have you had periodontal treatment? Yes ☐ No ☐

Is your mouth sensitive to hot or cold? Yes ☐ No ☐

Does any of your teeth hurt when you bite? Yes ☐ No ☐

When was the last time you were seen by a dentist? _____

When was your last dental cleaning appointment? _____

Have you had full set of x-rays or panoramic x-ray in the last 3 years? Yes ☐ No ☐

If yes, when and where? _____

Have you had any abnormal reactions to local or general anesthesia? Yes ☐ No ☐

Do you require pre-medication with an antibiotic? _____

Home Care and Habits

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes ☐ No ☐ If Yes, what kind? _____

Do you have an electric toothbrush? Yes ☐ No ☐

Do you snack often between meals? Yes ☐ No ☐

If yes, what kind of snacks and how often? _____

Do you drink sweetened beverages? Yes ☐ No ☐

If yes, what kind of how much per day? _____

Have you ever smoked? Yes ☐ No ☐

If Yes, do you still smoke? Yes ☐ No ☐

If Yes, how many pack per day? _____

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Medical History

Patient Name: _____ Date of Birth: _____

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is available upon request.

Are you under a physician's care?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever been hospitalized?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever had a major operation?	Yes ☐ No ☐	If Yes, please explain: _____
Have you ever had a serious head/neck injury?	Yes ☐ No ☐	If Yes, please explain: _____
Are you taking any medications?	Yes ☐ No ☐	If Yes, write Medications? _____
Do you take or taken Phen-Fen?	Yes ☐ No ☐	If Yes, please explain: _____
Do you take or taken Fosamax, Boniva, Actonel?	Yes ☐ No ☐	If Yes, please explain: _____
Are you on Blood Thinners?	Yes ☐ No ☐	If Yes, write Medications? _____
Do you have Knee or Hip Replaced?	Yes ☐ No ☐	
Do you use controlled substances?	Yes ☐ No ☐	

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

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

Have you ever had any serious illness not listed above? Yes ☐ No ☐ If Yes, please explain _____

Additional Information: _____

Women: Are you

Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptive? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthesia ☐ Acrylic ☐ Metal ☐ Latex ☐

Sulfa Drugs ☐ Others ☐ If yes, please explain _____

The questions on the form has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patients) health. I also understand it is my responsibility to inform dental office of any changes to the medical status.

Signature of Patient, Parent (or Guardian): _____ Date: _____

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Consent to Treat

This is to certify that I, _____ consent to the performing of the dental and oral surgical procedures agreed to be necessary of advisable, including the use of local anesthetics (if applicable), and I will assume the responsibility for fees associated with the procedures.

The information included in the health history is accurate to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian in case of Minor Date

Financial Responsibility

I, _____, authorize Esthetic Design Dental, to file insurance claim on my behalf. I as the patient or (responsible party) take full responsibility for my entire account balance.

Payment is due at the time of treatment. We accept cash, Visa, Mastercard, Discover, check, and Care Credit.

I understand that, prior authorization submitted to my insurance company is not a guarantee of payment but an estimate of benefits payable.

I understand that my dental insurance is a policy between me and the insurance company and that if there is a problem with a benefit that I am responsible to contact my insurance company.

Card on File Notice:

A credit or debit card is required to be placed on file prior to being seen. For ALL balances, if a billing statement is sent and payment is not received within 30 days, the stored credit or debit card will AUTOMATICALLY be charged for any balance due on the account.

_____ _____

Signature of Patient (or Responsible Party) Date

Esthetic Design Dental

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes ☐ No ☐
May we leave a message on your answering machine at home or on your cell phone? Yes ☐ No ☐
May we discuss your medical condition with any member of your family? Yes ☐ No ☐
If YES, please name the member(s) allowed:

Name: _____
First Middle Initial Last

Name: _____
First Middle Initial Last

This consent was signed by:

Name: _____
First Middle Initial Last

_____ _____
Patient (Parent/Guardian in case of Minor) Signature Date

_____ _____
Witness Signature Date

Esthetic Design Dental

COVID-19 PANDEMIC-PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense of smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19? If Yes, Test Date?		
Have you been tested for COVID-19 and are awaiting results?		
Are you Vaccinated? If Yes, Date(s): First Dose Date: Second Dose Date:		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness