Patient Registration

Aesthetic Dental Center

Patient's Name:_____ Date of Birth:_____

Mailing Address:_____ Social Security #:_____

City/State/Zip:_____

Primary Phone #:_____ Secondary Phone #:_____

Employer:_____ Work Phone:_____

Emergency Contact: _____ Emergency Contact Phone #:_____

Person Responsible for Account: *If same as above, please check here: ◯

Name:_____ Date of Birth:_____

Mailing Address:_____ Social Security #:_____

City/State/Zip:_____

City/State/Zip:_____

Primary Phone #:_____ Secondary Phone #:_____

Employer:_____ Work Phone:_____

****** Guarantor must be present for patients under the age of 18 ******

Patient Information:

Sex:
☐ Male ☐ Female

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status:
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student:
☐ Full Time ☐ Part Time

Preferred Dentist: _____ Preferred Hygienist: _____

Preferred Pharmacy: _____

Please let us know how you heard about us! Referred by: _____

Primary Insurance Information:
If insurance card is present, Do Not Complete

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

_____ _____

Secondary Insurance? Be Sure to Let Us Know!

Medical History

Aesthetic Dental Center

Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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, please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain: _____
Do you have any artificial joints?	◯ Yes	◯ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	
Are you on a special diet?	◯ Yes	◯ No	
Do you use tobacco?	◯ Yes	◯ No	If yes, please list type: _____
			# of years of use: _____
Do you use controlled substances?	◯ Yes	◯ No	If yes, list: _____
Are you taking any medication, pills or drugs?	◯ Yes	◯ No	If yes, list: _____
Are you required to take a pre-medication?	◯ Yes	◯ No	If yes, please explain: _____
Are you ***currently*** taking steroids?	◯ Yes	◯ No	_____
Have you ever been told you were a difficult intubation?	◯ Yes	◯ No	

Women: Are you: Pregnant/Trying to get pregnant? _____ Taking oral contraceptives? _____ Nursing? _____

Are you allergic to any of the following?

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

☐ Other _____

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

Chest/Heart			**Infectious Disease**			**Joint**		
Chest pains/Heart Trouble	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No	Arthritis/Gout	☐ Yes	☐ No
Congenital Heart	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Venereal Disease (STD)	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	MRSA	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	**Blood**		
Irregular Heartbeat	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	**Head/Mental Health**			Blood Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Alzheimer's	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No	Bruise Easily/Bleeding	☐ Yes	☐ No
Lungs/Respiratory			Drug Addiction	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Epilepsy Seizures	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	**Other**		
Frequent Cough	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Nervous	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No	GERD	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Hives/Rash	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No				Liver Disease/Jaundice	☐ Yes	☐ No
Kidney			**Endocrine**			Radiation Treatment	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Renal Dialysis	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Tumors/Growth	☐ Yes	☐ No
						Diabetes	☐ Yes	☐ No

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 Date

Aesthetic
Dental Center

Informed Consent for General Dental Procedures

You, the patient have the right to accept or reject dental treatment recommended by our dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Consent for anesthesia: In preparation for some treatment, anesthetics are needed. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaw and/or facial tissues that is usually temporary, however, in rare instances, such numbness may be permanent.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and give your consent by initialing each line item and signing at the bottom of the form.

1. **Treatment to be Provided**
   a. I understand that during my course of treatment that the following care may be provided: ~Examinations, Preventative Services, Restorations, Crowns, Bridges, Fillings, Impressions, any other general dentistry the Dr. deems necessary. _____
2. **Drugs and Medications**
   a. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock. _____
3. **Changes in Treatment Plan**
   a. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. _____
4. **Insurance**
   a.I give permission to the dental office to bill my insurance provider for the treatment provided, if applicable. _____
5. **Arriving Late for Appointment**
   a. I agree that, patients whose appointments are unable to be confirmed or who arrive late to appointment, may be asked to reschedule, pending availability on the day of the appointment. Arriving late pushes the provider's schedule behind, causing patients who arrive on time, to wait.

   b. I understand that a charge may be incurred for missed appointments. When a patient does not show or cancels just prior to their scheduled appointment time, that appointment then goes unused. This is unfortunate because there are often many other patients needing care that could have been seen at that time. Families/individuals who do not cancel an appointment at least three hours prior to the scheduled. appointment time, may be charged a fee of $40 for each missed appointment. The fee is not covered by insurance and will need to be paid prior to scheduling future appointments. Families/individuals who have multiple missed appointments may be asked to leave the practice. Our goal is to serve you in the most professional and timely manner possible. _____
6. **Receipt of Notice of Privacy Practices**
   a. I have received a copy of this office's Notice of Privacy Practices. _____

_____ _____ _____

Patient Name | Signature of Patient, Parent, or Guardian | Date

Aesthetic
Dental Center

Financial Policy

1. Payment is due the time services are rendered, unless prior financial arrangements have been made with the Office Manager.
2. Insured patients are expected to pay the estimated portion of treatment costs at the time of treatment, including any co-payment and deductible.
3. Out of state patients must pay in full at time of services regardless of insurance arrangement.
4. Non-participating providers: Should your insurance carrier not be contracted with the Aesthetic Dental Center. We will submit your insurance claim to your insurance company on your behalf. Payment for services, in full, is due at the time the services are rendered. Your insurance company should reimburse you per your benefits.
5. Overdue accounts are subject to service charges and if not taken care of in a timely manner, submission to a collection agency.
6. Fees for treatment are the obligation of the patient or person responsible for the account whether or not any insurance payment is collected.

It is not the responsibility of the Aesthetic Dental Center to track insurance benefits used and those which remain available to be used. The clinic staff will make their best effort to assist patients in tracking insurance benefits. However, any charges that exceed insurance benefits are the responsibility and obligation of the patient or person responsible for the account.

Signature:_____

Date:_____

HIPAA AUTHORIZATION

FOR TEXT & EMAIL COMMUNICATIONS

Patient Name:_____ DOB:_____

Please let us know how you would like to be contacted, mark all that apply:

☐ Text

☐ Phone

☐ E-Mail _____
E-Mail Address

I authorize the access, use, and/or disclosure of my information by Aesthetic Dental Center, including its providers and clinical administrative staff members in relation to our patient/provider relationship, as described below.

The type and amount of information to be accessed, used and/or disclosed is as follows: (1) communications between myself and Aesthetic Dental Center for treatment, payment and/or treatment operations via LightHouse 360's communications platform across digital, social media, texting, and/or other communication channels; and (2) transmissions of my patient information for treatment purposes only sent and/or received between Aesthetic Dental Center and my other treatment providers (or other providers to whom I may be referred to).

I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that Aesthetic Dental Center may not condition, prohibit, or prevent my treatment on whether I sign this Authorization.

I understand that, upon request, I will be given a copy of, or access to, this Authorization form after it is signed.

Signature of Patient/Personal Representative: _____

Aesthetic
Dental Center

Release of Patient Records & X-Rays

Patient: _____ **Date of Birth:** _____

Request records from:

Dental Office/Doctor: _____

City, State, Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

By signing this release, I hereby authorize the release of my patient records and/or X-rays relevant to dental treatment and request that they be transferred to the dental office listed below:

Aesthetic Dental Clinic
Dr. Krysta Sellers
1207 W Divide Ave Suite 1
Bismarck, ND 58501
PH: (701)214-5552
FX: (701)214-5656
info@aestheticdentalbismarck.com

_____
Patient/Guardian Name (please print)

_____ _____
Signature of Patient/Guardian Date

For office Use Only:
Date of last exam:_____ Date of last cleaning: _____
Date of last X-rays: Panoramic:_____ Bitewings:_____