

**REGISTRATION FORM FOR COSMETIC SMILES & GENERAL DENTISTRY**

**DATE** \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Marital Status:**  Single  Married  Widowed  Other **E-mail** \_\_\_\_\_

**Whom can we thank for referring you to our office?** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Employed By** \_\_\_\_\_

**Are you a full time student?**  Yes  No **If yes, which school?** \_\_\_\_\_

**Hobbies/Interests** \_\_\_\_\_

**Spouse's name** \_\_\_\_\_ **Spouse's Work Phone** \_\_\_\_\_

**Occupation of Spouse** \_\_\_\_\_ **Name of Employer** \_\_\_\_\_

**Person to Notify in an Emergency** \_\_\_\_\_ **Phone** \_\_\_\_\_

**If under 18 or full time student ONLY – Responsible Party Information**

**Mother's Name** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_ **B-day** \_\_\_\_\_

**Address** \_\_\_\_\_ **Employer** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_ **B-day** \_\_\_\_\_

**Address** \_\_\_\_\_ **Employer** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Dental Insurance Information**

**Employee's Name** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_ **B-day** \_\_\_\_\_

**Insurance Name** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Are you covered by a second insurance?** Yes No

**If yes, please present information to the front desk.**

## HEALTH QUESTIONS

*Please circle yes or no for the following question:* Is your general health good?      Yes      No  
 Do you have any allergies or hives to any foods, medication, metals, or earrings?      Yes      No  
 If yes, please list \_\_\_\_\_

Do you have or ever had any of the following:

Heart trouble	Yes	No	Hemophilia	Yes	No
Heart murmur	Yes	No	Malnourishment	Yes	No
Rheumatic fever	Yes	No	Systemic lupus erythematosus	Yes	No
Mitral valve prolapse	Yes	No	Rheumatoid arthritis	Yes	No
Leaky heart valve	Yes	No	HIV or AIDS	Yes	No
Infective endocarditis	Yes	No	Immunosuppression	Yes	No
Artificial heart valve(s)	Yes	No	Radiation therapy	Yes	No
Artificial joint(s)	Yes	No	Asthma	Yes	No
Diabetes	Yes	No	Bleeding problems	Yes	No
Antidepressant Medications	Yes	No	Hepatitis, cirrhosis, Liver disease	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No
Latex sensitivity	Yes	No	Have you ever taken an appetite suppressant? (Fen phen)	Yes	No
Fainting or Dizzy spells	Yes	No	Abnormal bleeding problems	Yes	No
Stomach or intestinal ulcers	Yes	No	Kidney or bladder disease	Yes	No
<i>Females: Are you pregnant?</i>	Yes	No	Stroke	Yes	No

Is there any other information about your health which should be known? \_\_\_\_\_

Please list ALL current medications \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

I \_\_\_\_\_, give Dr. Schefdore permission to share my health information with the following person(s) Name/relation to patient \_\_\_\_\_  
 \_\_\_\_\_ contact phone # \_\_\_\_\_

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

I understand that as a service to me Cosmetic Smiles & General Dentistry will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

I give permission for Dr. Schefdore to share my blood screening results and any oral conditions with my physicians

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

I authorize the use of my x-rays/photographs for use in seminars or publications of Dr. Ronald Schefdore.

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

### ONLY IF YOU HAVE INSURANCE: SIGNATURE ON FILE

So you do not have to sign an insurance claim form at every visit, Cosmetic Smiles & General Dentistry will maintain this "signature on file" for you. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize any provider, insurer, or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan administrator or its authorized agent for the purpose of determining benefits payable.

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS:** I hereby authorize insurance payment to Cosmetic Smiles & General Dentistry.

*Signature* (patient or parent if minor) \_\_\_\_\_ *Date* \_\_\_\_\_

**American Diabetes Association (please circle)**

- Does your father, mother, or any siblings have diabetes? Yes or No
- Are you of African American, Hispanic, or American Indian heritage? Yes or No
- Are you more than 15lbs. overweight? Yes or No
- Do you ever go a full day without physical activity for at least 30min? Yes or No
- Do you have high blood pressure? Yes or No
- Are you over the age of 45? Yes or No

**Obstructive Sleep Apnea Screening**

- Do you snore? Yes or No
- Are you tired, fatigued or sleepy during the day? Yes or No
- Do you have high blood pressure? Yes or No
- Do you ever choke or gasp while you sleep? Yes or No
- Have you had an overnight sleep study? Yes or No

**Dental Information...**

- Are you concerned about bad breath?  Yes  No
- Do you ever have a bad taste in your mouth?  Yes  No
- Do your gums bleed when you brush or floss?  Yes  No
- Have your gums receded?  Yes  No
- Have you noticed any loose teeth?  Yes  No
- Have had any periodontal (gum) surgery?  Yes  No
- Would you say that you have had a  minimal  moderate  major amount of previous dental treatment?
- Would you guess that you *need* a  minimal  moderate  major amount of dental treatment now?
- Would you say that you have a  low  moderate  high susceptibility to cavities?
- Do you have sore shoulders?  Often  Occasionally
- Do you have neck aches?  Often  Occasionally
- Do you have headaches?  Often  Occasionally
- Please describe any other dental information that may be important to us: \_\_\_\_\_
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## **WELCOME TO COSMETIC SMILES & GENERAL DENTISTRY**

It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines:

**CANCELLATION POLICY:** There are many of times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give our office an advanced notice of their need to cancel a scheduled appointment, this time can then be allocated to these patients in urgent need of treatment. This way we can service all of our patients in the best way possible.

Bearing these special needs in mind, our office requires a minimum of 48 hours notice if an appointment must be cancelled. If less than 48 hours notice has been given to cancel an appointment, a \$50 fee will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, then a \$75 fee will be assessed. Please note that this fee is not covered by dental insurance and payment is the patient's responsibility.

\*Exceptions will be made for illness or personal tragedy.

**PAYMENT OPTIONS AND PLANS:** Unless prior arrangements have been made, payment is due on the day of service for fees totaling less than \$300 with cash, check, or credit card. Please note, not all services may be covered by insurance carriers, and every insurance plan has its own exceptions. It becomes the patients' responsibility to cover procedures that are not covered by their insurance plan. As a courtesy to you, we will call your insurance company and inform you of what they said your coverage is. At no cost to you, we will fill out, submit, and write any letters to your insurance company so you can maximize your dental benefits.

**PAYMENT IN FULL** – Lower your dental bill by paying in full - A full 5% discount will be given when you pay in full the day of service if your total treatment is \$300 or more.

For fees totaling over \$300, we have payment options available. We have a 12-month interest-free financing program through Citi Health Card and Care Credit. There are also extended payment plans for up to 48-months. If you have dental insurance, we can have you pay your estimated portion of the bill and wait for the insurance to pay their estimated portion. However, you are responsible for the whole bill in its entirety. If there is an over payment, we will refund you the difference or if the insurance payment is less than the balance, you will need to pay the difference.

Continued on the next page – please turn over

**I have read the above policies of Cosmetic Smiles & General Dentistry and understand my responsibility as a patient at this office.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### **NOTE TO PATIENTS WITH INSURANCE**

We are happy to process any insurance claims as a service to you at no charge. Please keep in mind that any estimate we provide to you is only an estimate and that you are responsible for all fees in their entirety. We are proud that our fees reflect the time that the doctor spends each patient as well as the overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules and are often above insurance allowances due to the quality of care, time, and materials we use.

You may wish to complain to your company's benefit representative, should your benefits be less than you expected.

We look forward to taking care of you and your loved ones. If you like our personalized service, gentle care, and great quality of our dentistry, please tell others.

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### **Musical Tastes?**

	<b>Love it!</b>	<b>It's OK</b>	<b>Dislike!</b>
<b>Easy Listening</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>New Age</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Classical</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Oldies</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Blues &amp; Jazz</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eclectic/Mix</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other Music or Radio Station:** \_\_\_\_\_

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## **Photography**

Dr. Schefdore often takes pictures to better explain certain aspects of your existing dental health or planned treatment to you. We request your permission to show these photographs to better explain treatment options to other patients (as you will be shown photos for the same reason). Since Dr. Schefdore has a reputation as an expert on Cosmetic Dentistry, he also makes presentations to other dentists where the pictures are invaluable in explaining the latest techniques and the results that can be achieved when done precisely.

***My signature acknowledges that:***

*The questions have been answered truthfully and completely,  
Photographs of me may be used for educational purposes as stated  
above, I understand the office policy with keeping appointments,  
I have received a copy of the Notice of Privacy Practices, and  
I understand and will comply with the office financial agreement.*

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Patient's Signature (or Parent if a minor)

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Date

We strive to deliver the type of service and atmosphere that you should expect from a caring dental office.

Thank you – Dr. Ron Schefdore & Staff