Patient Registration

First Name:_____ Last Name:_____

Patient is: □ Policy Holder □ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name:_____

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Ext:_____

Birth Date:_____ Social Security:_____

□ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Patient Information

Address:_____ Marital Status_____

City: _____ State, Zip: _____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Ext:_____ Referred By:_____

Birth Date:_____ Age: _____ Social Security:_____

Email: _____ □ I would like to receive corresponses via e-mail.

---------- Section 2 ---------- Section 3 ----------

Employment Status : □ Full Time □ Part Time □ Retired Emergency Contact: _____

Student Status: □ Full Time □ Part Time Phone Number: _____

Medicaid ID: _____ Pref. Dentist: _____ Emergency Contact 2: _____

Employer ID: _____ Pref. Pharmacy: _____ Phone Number : _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of insured: _____ Relationship to Patient: □ Self □ Spouse □ Child □ Other

Employer: _____ Employee Address: _____

City/ State, Zip: _____ Occupation:_____

Insurance Company: _____ Insurance Address:_____

City/ State, Zip: _____

Rem. Benefits: _____ Rem. Deductible: _____

Secondary Insurance Information

Name of insured: _____ Relationship to Patient: □ Self □ Spouse □ Child □ Other

Employer: _____ Employee Address: _____

City/ State, Zip: _____

Insurance Company: _____ Insurance Address:_____

City/ State, Zip: _____

Rem. Benefits: _____ Rem. Deductible: _____

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MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

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, please explain: _____
Have you been Hospitalized or had a major operation?	□ Yes □ No	If yes, please explain: _____
Have you ever had a serious neck or head injury?	□ Yes □ No	If yes, please explain: _____
Are you taking any medications, pill, or drugs?	□ Yes □ No	If yes, please explain: _____
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	

Women only: Are you

Pregnant / Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Other if yes, please explain:

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

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

Have you ever had any serious illness not listed above? □ Yes □ No if yes, please explain: _____

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 GAURDIAN _____ **DATE** _____

138 N. San Gabriel Blvd., San Gabriel, CA 91775 TEL: (626)287-2625
web: www.instyledental.com e-mail: instyledental@yahoo.com

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DENTAL HISTORY

Name: _____ Date: _____

Previous Dentist: _____ What was done: _____

Last Dentist Visit: _____ Most recent X-rays: _____

What is your main concern today? _____

With the recent advancement in materials and techniques, many of our patients are asking more questions about cosmetic dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

Please circle yes or no:

Are you presently having a toothache or pain?	Y	N
Do your gums bleed when you brush or floss?	Y	N
Are any teeth sensitive to air, biting, hot, cold, or sweets?	Y	N
Have you had teeth extracted?	Y	N
Does food catch between your teeth?	Y	N
Do you frequently clench or grind your teeth?	Y	N
Do you have any persistent bad taste odor in your mouth?	Y	N
Do you like the appearance of your teeth?	Y	N
Do you think you have a "gummy" smile?	Y	N
Are you interested in whiter teeth?	Y	N
Are your teeth as straight as you would like them to be?	Y	N
Are you happy with the length, width and shape of your teeth?	Y	N
Do you have any chipped teeth?	Y	N
Do you have any missing teeth?	Y	N
Do you have discoloration, stains or spots in your teeth?	Y	N
Do you have silver fillings that you would like to change to white?	Y	N
Has anyone you've known had any cosmetic dentistry done that interests you?	Y	N

If there was anything else you could change about the appearance of your teeth, what would it be?

_____

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InStyle Dental

FINANCIAL POLICY

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

METHOD OF PAYMENT: Full payment is due at the time of service.

1. Cash, Check or Credit Card (Master Card and Visa)
2. Dental Benefits of Supplements (Described below)
3. Outside financing available upon approved credit

DENTAL INSURANCE

Please Circle one: **BILL CLAIMS IN HOUSE or SELF BILL CLAIMS**

1. If you have dental insurance, our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company.
2. As a courtesy to you, we will file your insurance claim and accept assignment of benefits if you have signed the insurance payment authorization form. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover, others they will cover partially, and some tat will not cover at all.

RELATED INFORMATION

1. Return checks are subject to a $25.00 Non-Sufficient Fund charge and balances older than 30 days will be subjected to an additional billing fee of 5% for every monthly statement sent. These additional fees will be applied to the unpaid balance at the end of the month.
2. In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court cost, and collection agency fees.) There is also a $50.00 fee to report your account to TRW.
3. Your appointment time has been reserved exclusively for you. Changes in your appointments affect your preventive care. A 48 – hour notice is needed to avoid any charges. Failure to do so may result in a broken appointment fee. If your account becomes delinquent for more than 60 days and you are in need of additional treatment, fully payment must be made prior to the time of service.

I have read and understand that above information. I understand I am responsible (regardless of my insurance) for any charges incurred for services rendered.

NAME (Please Print) _____

SIGNATURE _____ **DATE** _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF
DENTAL FACT SHEET AND NOTICE OF PRIVACY POLICY.

I, _____, acknowledge I have received from Brian M. Kar, D.M.D. a copy of the dental fact sheet (dated May 2004) and notice of privacy policy.

Name (print) _____

Signature _____ **Date** _____

OFFICE USE ONLY

On _____, acknowledge of receipt of notice of privacy policy form was delivered. The form was not signed due t

- **COMMUNICATION BARRIER WHICH PREVENTED ACKNOWLEDGEMENT**
- **AN EMERGENCY WHICH PREVENTED ACKNOWLEDGEMENT**
- **A REFUSAL TO SIGN**
- **OTHER**

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