



REGISTRATION

Patient Name (Last, First, Middle): _____ Title: _____
 SS #: _____ - _____ - _____ Birthdate: ____/____/____ Preferred Name: _____
 Address: _____ Town _____ State _____ Zip _____
 Home Phone: _____ Cell Phone: _____
 E-Mail Address: _____ Marital Status: S / M / D / W Sex: M / F
 Would you like a Text Message appointment reminder? Yes / No
 Employer: _____ Work Phone: _____
 Whom may we thank for referring you? _____
 Are any other family member's patients of this office? Name: _____ Relationship: _____
 Which family member is financially responsible for payment of this account? _____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____
 Address: _____ Town _____ State _____ Zip _____
 SS # (Required): _____ - _____ - _____ Birthdate (Required): ____/____/____
 Employer: _____ Work Phone: _____
 Insurance Company: _____ Group #: _____ Employee ID#: _____

Please provide us with your insurance card so we may make a copy for our records.

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____
 Address: _____ Town _____ State _____ Zip _____
 SS # (Required): _____ - _____ - _____ Birthdate (Required): ____/____/____
 Employer: _____ Work Phone: _____
 Insurance Company: _____ Group #: _____ Employee ID#: _____

PATIENT TREATMENT CONSENT

- I authorize appointment reminders such as voicemail messages, postcards, letters or e-mail confirmations.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered to me or to my dependents.

Patient / Parent or Guardian Signature: _____ Date: _____

It is customary to pay for professional procedures when they are rendered unless other arrangements have been made in advance. Preferred method of payment Visa/MC/Discover Check Cash



Weaver
Reckner
Reinhart
DENTAL ASSOCIATES

Creating Smiles For All Ages

Medical History

Your current health: Good Fair Poor
Are you currently under the care of a physician? Yes No

Please Explain: _____

Physician Name: _____

Are you taking any prescriptions? Yes No
Over- the- counter drugs? Yes No

Please list each one: _____

Do you take a dental premedication? Yes No Why? _____

Do you smoke or use tobacco in any other form? Yes No

Have you even taken Bisphosphonates? Yes No
(Boniva-Fosamax-Actonel-Skelif-Diaconel-Aredia-Zometa)

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other
Y	N	Jewelry/Metal			

Do you have trouble with dental anesthetic(Novocain)? Yes No

Please list any other drugs/materials that you are allergic to:

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week # _____ Nursing? Yes No

Have you ever had any of the following? (Please circle option that applies)

- | | | | | | |
|---|---|---|---|---|----------------------------------|
| Y | N | Alcoholism/Drug Addiction | Y | N | Hearing Problems |
| Y | N | Anemia/ Radiation Treatment | Y | N | Hemophilia/Abnormal Bleeding |
| Y | N | Artificial Bone/Joints/Valves | Y | N | Hepatitis/ Type _____ |
| Y | N | Arthritis | Y | N | High/Low Blood Pressure |
| Y | N | Asthma | Y | N | HIV+/AIDS |
| Y | N | Blood Transfusion | Y | N | Hospitalized for Any Reason |
| Y | N | Cancer/Chemotherapy | Y | N | Kidney Problems |
| Y | N | Congenital Heart Defect | Y | N | Mitral Valve Prolapse |
| Y | N | Diabetes | Y | N | Nervous or Mental Disorder |
| Y | N | Difficulty Breathing/ Lung Problems | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Emphysema/ Glaucoma | Y | N | STD/HPV/Other Infectious Disease |
| Y | N | Epilepsy/Seizures/Fainting Spells | Y | N | Shingles |
| Y | N | Fever Blisters/ Herpes | Y | N | Sickle Cell Disease/Traits |
| Y | N | Heart Attack/Stroke | Y | N | Sinus Problems |
| Y | N | Heart Murmur | Y | N | Tuberculosis (TB)/ When? _____ |
| Y | N | Heart Surgery/Pacemaker | Y | N | Ulcers/Colitis |
| Y | N | Thyroid Problems/Adrenal/Pituitary | Y | N | Stomach Problems |
| Y | N | Headaches, if YES, please describe: _____ | | | |

Please list any serious medical condition(s) that you have ever had:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____



Weaver, Reckner & Reinhart Dental Associates is happy to file insurance claims, provide information on your behalf, and pre-authorize certain services, however, **the ultimate responsibility of the account remains with the patients/subscriber.**

Each patient is different, and we make every attempt to work with you as an individual.

Effective January 1, 2005, Weaver, Reckner & Reinhart Dental Associates has adopted the following payment procedures.

*At the time of service, payment or co-payment is expected for any portion not covered by dental insurance. We will estimate your portion that is not covered by insurance and the following payment options are available:

1. You may pay your percentage at the time of visit by cash, check, Visa, Mastercard or Discover.
2. We are able to swipe your credit card and keep your credit card number on file in the computer. After final insurance payment is received, we will charge your card the exact balance.
3. Arrangement may be made in advance for interest free financing through Care Credit.

***It is customary to pay for professional services when rendered.
Any other arrangement must be made in advance.***

One of the benefits our office provides is the service of filing your insurance claims and waiting for their payments on your behalf. Therefore, we appreciate your prompt payment of the portion your insurance will not cover. If the co-payment is not paid at your visit, one statement will be sent without charge.

PLEASE RETAIN THIS COPY

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