Patient Registration

RacineDentalGroup s.c.

Smile after beautiful smile since 1969.

Patient information

Name _____

SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Male ❍ Female ❍

If patient is a minor: Name of mother _____

Name of father _____

Minor resides with: Mother ❍ Father ❍ Both ❍ Other ❍ _____

Person to notify in case of emergency (other than residence) _____

Relationship _____ Phone # _____

Account information (person responsible for account)

Name _____ SS # _____ Date of birth _____

Relationship _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business address _____ Phone # _____

Spouse's name _____ SS # _____ Date of birth _____

Relationship _____ Phone # _____

Address (if different) _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business address _____ Phone # _____

Dental insurance information

Primary insurance company _____ Phone # _____

Insured's name _____ SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____ Effective date _____

Union/local # _____ Group # _____ Member # _____

Secondary insurance company _____ Phone # _____

Insured's name _____ SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____ Effective date _____

Union/local # _____ Group # _____ Member # _____

Treatment information

Purpose of visit _____ Is this your first visit to our office? YES ❍ NO ❍

Previous dentist _____ Date of last exam _____

Other family members seen by us _____

Who may we thank for referring you to our office? _____

Please review information on back and sign ➔

Accountability Confirmation

Financial information – I understand I am financially responsible for payment in full of all my accounts. A service charge of 2% per month will be added to all account balances over 60 days old; this is an annual percentage rate of 24%. I understand that if my account becomes delinquent, I may be referred to a third party for collection. I also understand that future dental services may be limited for all persons under my account until my account is current.

Insurance disclosure - *I understand and acknowledge that it is my sole responsibility to contact my insurance company and/or employer to assure proper approval for services and coverage at Racine Dental Group, S.C.* I understand that my insurance carrier may pay less than the actual fee for services. In order to expedite the preparation, mailing and processing of my insurance, I hereby authorize Racine Dental Group, S.C. to provide the insurance company(s) claim administrator and consulting care professionals information concerning health care advice and/or treatment provided. This information will be used for the purpose of evaluating and administering claims for benefits and I authorize Racine Dental Group, S.C. to receive payment of any insurance benefits otherwise payable to me. I understand and acknowledge that it is my sole responsibility to obtain payment from any third party in the event that my insurance does not pay any balance in full.

Release of information - I attest to the accuracy of the information within this form and agree to provide Racine Dental Group, S.C. with any changes. I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Any information obtained will be used for the purpose of insurance filing, payment and collection of fees for services rendered.

Note to parents of minor children:
Per Wisconsin Statute 766.55, parents of minor children are jointly and severally responsible for any and all balances resulting from services rendered to minor dependents. Dependent children will be placed under the account of the parent or guardian: with whom the minor child resides. The parent or guardian with whom the dependent child resides will receive all documentation pertaining to the account such as statements, recall notices and insurance notices.

Racine Dental Group, S.C. does not get involved in domestic disputes such as divorce decrees, parental liabilities, custody, or any other personal family issue. These personal matters are not the responsibility of Racine Dental Group, S.C. Racine Dental Group, S.C. will not provide documentation pertaining to the account to any individual not identified on the reverse except at the request of the account holder.

Written Financial Policy

Thank you for choosing Racine Dental Group. We have many payment options available to our patients. Our goal is to give each person an opportunity to afford the dentistry they need and want.

You can choose from:

➔ Cash, Check, Visa, MasterCard or Discover Card

➔ Convenient monthly payment plans from CareCredit*

- Allow you to pay over time
- No annual fees or pre-payment penalties

➔ If you have no dental insurance:

- We offer a 5% courtesy accounting adjustment when payment is made for your treatment with cash or check prior to or upon completion of care.
- You can also participate in our SmileAssist™ program, which offers a year's worth of preventative dental care for one low price, dental care for the whole family and additional discounts. Talk with our SmileAssist Administrator for details: (262) 619-7739.

Please note:
Racine Dental Group requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Insurance: If you have dental insurance, our knowledgeable team will file all the necessary paperwork with your insurance company. We will provide you with an estimate of your coverage and benefits. Your estimated portions are due at the time of service.

A fee of $30 is charged for patients who miss or cancel more than one time in a calendar year without 24-hour notice.

Racine Dental Group charges $35 for returned checks.

_____ _____

Patient, parent or guardian signature Date

_____

Patient name (please print)

* Subject to credit approval

Medical History

Name _____

Date of birth _____

Account # _____ Male ❍ Female ❍

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In the following questions, answer yes or no, whichever applies.
Your answers are for our records only and will be considered confidential.

Are you now under the care of a physician? YES ❍ NO ❍

If so, what is the condition being treated? _____ Date last physical _____

Physician's name _____ Dr. phone # _____

Do you have or have you ever had?:

Abnormal bleeding Y ❍ N ❍
Alcoholism/drug addiction Y ❍ N ❍
Anemia or blood disorders Y ❍ N ❍
Arthritis Y ❍ N ❍
Asthma Y ❍ N ❍
Cancer or tumor Y ❍ N ❍
Diabetes Y ❍ N ❍
Epilepsy, seizures Y ❍ N ❍
Fainting spells Y ❍ N ❍
Glaucoma Y ❍ N ❍
Herpes or other STD Y ❍ N ❍
HIV Y ❍ N ❍
Immune deficiency or lupus Y ❍ N ❍
Kidney disease Y ❍ N ❍
Liver disease or hepatitis A, B, C Y ❍ N ❍
Osteoporosis Y ❍ N ❍
Radiation (location:_____) Y ❍ N ❍
Sinus condition Y ❍ N ❍
Stomach ulcers Y ❍ N ❍
Thyroid disease Y ❍ N ❍
Angina (chest pain) Y ❍ N ❍
Heart attack/TIA Y ❍ N ❍
Heart surgery Y ❍ N ❍
Heart valve replacement Y ❍ N ❍
Pacemaker Y ❍ N ❍
Rheumatic fever Y ❍ N ❍
High blood pressure Y ❍ N ❍
Previous stroke Y ❍ N ❍
Loud snoring Y ❍ N ❍
Daytime fatigue, tired/sleepy Y ❍ N ❍
Stop breathing during sleep Y ❍ N ❍
Restless sleep Y ❍ N ❍
Clenching/grinding during sleep Y ❍ N ❍
GERD/acid reflux Y ❍ N ❍
Xerostomia (dry mouth) Y ❍ N ❍

Women:

Are you pregnant? Y ❍ N ❍
Take birth control pills? Y ❍ N ❍
Are you breast feeding? Y ❍ N ❍

Have you been diagnosed with sleep apnea? YES ❍ NO ❍ Do you wear a CPAP? YES ❍ NO ❍

Do you smoke or use other tobacco products? YES ❍ NO ❍ # per day _____ # of years _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? YES ❍ NO ❍ Date _____

Have you been told you need antibiotics prior to a dental visit? YES ❍ NO ❍

Do you have any disease, condition or problem not listed above? _____

_____

Are you taking any of the following?:

Antibiotics or sulfa drugs Y ❍ N ❍
Anticoagulants (blood thinners) Y ❍ N ❍
Medicine for high blood pressure Y ❍ N ❍
Cortisone or other steroids Y ❍ N ❍
Aspirin Y ❍ N ❍
Tranquilizers or antidepressants Y ❍ N ❍
Orinase, insulin or other diabetes drugs Y ❍ N ❍
Digitalis or drugs for heart trouble Y ❍ N ❍
Nitroglycerin Y ❍ N ❍
Osteoporosis (bone density) drugs Y ❍ N ❍

Allergic or reacted adversely to?:

Local anesthetics Y ❍ N ❍
Penicillin or other antibiotics Y ❍ N ❍
Barbiturates, sedatives or sleeping pills Y ❍ N ❍
Aspirin, acetaminophen or ibuprofen Y ❍ N ❍
Sulfa Y ❍ N ❍
Codeine or other narcotics Y ❍ N ❍
Latex Y ❍ N ❍
Metals Y ❍ N ❍
Other_____

_____

List all medications including any over-the-counter medications, dietary or herbal supplements: _____

_____

_____

The above information that I have provided is true and correct to the best of my knowledge.

_____ _____ _____ _____

Patient signature Date Doctor signature Date

Doctor comments:

Dental History

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Name _____

Date of birth _____

Account # _____ Male ❍ Female ❍

Have you had regular dental visits? YES ❍ NO ❍

Date of last dental visit _____

Previous dentist name _____ Phone # _____

Are you having problems now? YES ❍ NO ❍ If yes, specify _____

_____

Is your mouth dry? ..... YES ❍ NO ❍

Are your teeth sensitive to: Hot ❍ Cold ❍ Sweets ❍ Pressure ❍

Do your gums bleed when you brush or floss? ..... YES ❍ NO ❍

Do you have a history of periodontal disease requiring deep cleaning or gum surgery? ..... YES ❍ NO ❍

Do you have a family history of periodontal disease? ..... YES ❍ NO ❍

If any teeth have been replaced, how/when?

Fixed bridge ❍ Date _____

Removable (partial) ❍ Date _____

Denture ❍ Date _____

Implants ❍ Date _____

Have you ever had any problems or complications with previous dental treatment? _____

_____

Are you anxious about receiving any dental treatment? ..... YES ❍ NO ❍

Are you anxious about receiving anesthetic? ..... YES ❍ NO ❍

Have you worn braces? ..... YES ❍ NO ❍

Do you have any of the following?:

Frequent headaches ..... Y ❍ N ❍

Frequent neckaches ..... Y ❍ N ❍

Dizziness, lightheadness ..... Y ❍ N ❍

Earaches, ringing in ears ..... Y ❍ N ❍

Jaws clicking or popping ..... Y ❍ N ❍

Pain, soreness in facial muscles ..... Y ❍ N ❍

Limited mouth opening ..... Y ❍ N ❍

Pain in shoulders ..... Y ❍ N ❍

Pain, stiffness in back ..... Y ❍ N ❍

Numbness in arms, fingers ..... Y ❍ N ❍

Do you have any signs of apnea?:

How likely are you to doze off or fall asleep while watching TV, sitting inactive in a public place, or as a passenger in a car?

Not likely ❍ Slight chance ❍ Moderate chance ❍ High chance ❍

On average in the past month, how often have you snored or been told that you snored?

Never ❍ Rarely ❍ Sometimes ❍ Frequently ❍ Almost always ❍

Do you ever wake up choking or gasping?

Never ❍ Rarely ❍ Sometimes ❍ Frequently ❍ Almost always ❍

Have you been told that you stop breathing in your sleep or wake up ckoking or gasping?

Never ❍ Rarely ❍ Sometimes ❍ Frequently ❍ Almost always ❍

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ❍ Rarely ❍ Sometimes ❍ Frequently ❍ Almost always ❍

Do you currently wear a mouthguard? YES ❍ NO ❍ In the past? YES ❍ NO ❍

Do you have discolored teeth that bother you? ..... YES ❍ NO ❍

Would you like your smile to look better or different? ..... YES ❍ NO ❍

Are there any dental concerns you would like us to address specifically? _____

_____

_____

If you could change anything about your smile, what would it be? _____

_____

_____

Feedback Form

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How did you hear about us?

New patient? Let us know how you found out about Racine Dental Group. Please check ALL that apply. Not a new patient? Check **"N"** below:

- ❍ **A.** Building sign
- ❍ **B.** Phone book
- ❍ **C.** Search engine (Google, Yahoo, etc.]
- ❍ **D.** Mail promotion
- ❍ **E.** Our website (racinedentalgroup.com]
- ❍ **F.** Newspaper
- ❍ **G.** Event we sponsored _____
- ❍ **H.** Your insurance company _____
- ❍ **I.** Your employer _____
- ❍ **J.** Friend/family referral _____
- ❍ **K.** Dentist/doctor referral _____
- ❍ **L.** Health Care Network/Donated Dental Services
- ❍ **M.** Other _____
- ❍ **N.** Not a new patient

How do you want to hear from us?

Let us know if we can enroll you in our online and automated patient communication system. It will give you the ability to:

- Request and confirm appointments online
- Receive text messages, email and automated phone appointment reminders
- Get dental health updates from our doctors and staff
- Stay up to date on Racine Dental Group news
- Refer your friends and family online

Sound good? Fill in the information and sign/date below to allow us to use your information to communicate with you as described above:

Name _____

Cell phone _____ Home phone _____

Email _____

Signature _____ Date _____

IMPORTANT: We use a third party to provide these communication services. They are required by law to sign a contract agreeing to protect the confidentiality of your Patient Health Information (PHI). Our affiliates do not sell, share or rent our users' personal identifiable information unless required by law, do not send any email or other communication without a user's permission, and do not send spam.

TO OPT OUT: You may opt out of communications at any time by clicking the UNSUBSCRIBE link in an email footer or by replying STOP to a text message. Standard text messaging rates apply.

MAIN (262) 637-9371 **FAX** (262) 637-3071 **WEB** racinedentalgroup.com **ADDRESS** 1101 South Airline Road, Racine, Wi 53406