PATIENT REGISTRATION

First Name:___________________ Last Name:_______________________ Middle Initial:____
Preferred Name:__________________________

Patient Information:

Address:_________________________________Address 2:___________________________________
City:________________________________State/Zip:________________________________
Home Phone:_________________Cell Phone:__________________Work Phone:_________________
Birth Date:________________Age:______ Social Security Number:__________________________
Gender: Male Female
Marital Status: □Maried □Single □Divorced □Separated □Widowed
To Receive correspondence via email, please provide email address:_____________________________
Employment Status:□Full-time □Part-time□Retired □Unemployed □Disabled
Student Status:□ Full-time □Part-time □None If student: Name of School_____________________
Previous Dentist:_________________________ Date of Last Dental Visit:_______________________
Preferred Pharmacy:______________________ Pharmacy # (if known):_______________________
Emergency Contact:_______________________ Emergency Contact#__________________________

Responsible Party(if someone other than patient):

First Name:____________________________Last Name:______________________Middle Initial:____
Adress:______________________________ Address 2:______________________________________
City, State, Zip:____
Home Phone:____________________Cell Phone:_________________Work Phone:________________
Birth Date:____________________Age:_____ Social Security Number:___________________________
Relationship to Patient:□Spouse □Parent □Insurance Holder □Other(please specify)

Primary Dental Insurance Information:

Name of Insured:____
Relationship to Insured: □Self □Spouse □Child □Other(please specify)
Insured Social Security #:________________________ Insured Birth Date:_________________________
Employer:____
Employer Address:____
Insurance Company:____
Insurance Company Address:____
****Please provide us with your insurance card so we may make a copy for your records.
Our office files your Primary insurance as a courtesy for our patients.

Secondary Dental Insurance Information: Please circle YES or NO

Name of Secondary insurance Company:____
**Please provide us with your insurance card so that we may make a copy for your records.
It is necessary for us to have secondary info on file.

CRYSTAL SMILE FAMILY DENTISTRY MEDICAL HISTORY

Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, you mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's car now/name/number Yes No Explain___________________

Have you ever been hospitalized or had major operation? Yes No Explain___________________

Have you ever had a serious head and neck injury? Yes No Explain___________________

Are you taking any medications, pills, or drugs? Yes No Explain___________________

Do you take, or have you ever taken, phen-fen or redux? Yes No Explain___________________

Have you takn Fosamax,Boniva, Actonel or other medication containing bisphosphonate? ____________

Are you on a special diet? Yes No Explain___________________

Do you use tobacco? Yes No Explain___________________

Do you use controlled substances? Yes No Explain___________________

Would you like to change anything about your teeth? Yes No Explain___________________

WOMEN ONLY

Any Possibility of being pregnant? Y N	Nursing? Y N	Taken oral Contraceptives? Y N

ALL PATIENTS

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other______________________

AID/HIV POSITIVE	Y/N	DIABETES	Y/N	HERPES	Y/N	RHEUMATISM	Y/N
ALZHEIMER'S	Y/N	DRUG ADDICTION	Y/N	HIGH BLOOD PRESSURE	Y/N	SCARLETT FEVER	Y/N
ANAPHYLAXIS	Y/N	EASILY WINDED	Y/N	HIGH CHOLESTEROL	Y/N	SHINGLES	Y/N
ANEMIA	Y/N	EMPHYSEMA	Y/N	HIVES OR RASH	Y/N	SICKLE CELL	Y/N
ANGINA	Y/N	SEIZURES	Y/N	HYPOGLYCEMIA	Y/N	SINUS TROUBLE	Y/N
ARTIFICIALHEART VALVE	Y/N	EXCESSIVE BLEEDING	Y/N	IRREGULAR HEARTBURN	Y/N	SPINA BIFIDA	Y/N
ARTIFICIAL JOINT	Y/N	FAINTING SPELLS/DIZZINESS	Y/N	LEUKEMIA	Y/N	STROKE	Y/N
ASTHMA	Y/N	FREQUENT COUGH	Y/N	LIVER DISEASE	Y/N	SWELLING OF LIMBS	Y/N
BLOOD DISEASE	Y/N	FREQUANT DIARRHEA	Y/N	LOW BLOOD PRESSURE	Y/N	THYROID DISEASE	Y/N
BLOOD TRANSFUSION	Y/N	GENITAL HERPES	Y/N	LUNG DISEASE	Y/N	TONSILLITIS	Y/N
BREATHING PROBLEMS	Y/N	GLAUCOMA	Y/N	MITRAL VALVE PROLAPSE	Y/N	TUBERCULOSIS	Y/N
BRUISE EASILY	Y/N	HAY FEVER	Y/N	OSTEOPOROSIS	Y/N	TUMORS OR GROWTHS	Y/N
CANCER	Y/N	HEART ATTACK/FAILURE	Y/N	PAIN IN JAW JOINTS	Y/N	ULCERS	Y/N
CHEMOTHERAPY	Y/N	HEART MURMUR	Y/N	PARATHYROID DISEASE	Y/N	VENEREAL DISEASE	Y/N
COLD SORES/BLISTERS	Y/N	HEART TROUBLE/DISEASE	Y/N	RADIATION TREATMENT	Y/N	CONGENTAL HEART DISEASE	Y/N
SLEEP APNEA	Y/N	HEMOPHILIA	Y/N	RECENT WEIGHT LOSS	Y/N	CONVULSIONS	Y/N
HEPATITIS A	Y/N	RENAL DIALYSIS	Y/N	CORTISONE MEDICINE	Y/N	HEPATITIS B OR C	Y/N
RHEUMATIC FEVER	Y/N		Y/N		Y/N		Y/N

Have you ever had ANY serious illness or SURGERY NPT listed above________________________________

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:_____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I,________________________________, have received a copy of this office's notice of privacy practices.

Please Print Name:____

Signature:____

Date:____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____Comminication barriers prohibited obtaining acknowledgement

____An emergency situation prevented us from obtaining acknowledgment

___Other (Please specify):

____

____

PRACTICE SCHEDULING AND FINANCIAL POLICY

We welcome you to the CrystalSmile Family Dentistry, the practice of Jing Zhou., DDS, PA, and are committed to providing you the best treatment possible. Our team is dedicated to ensure that your overall experience with us is successful and pleasurable.

To enable us to best serve all of our patients, please review the following policies. If we focus together on these policies, you will enable us to provide you and other patients with the care that is expected and deserved.

Appointments

When an appointment is established for you, we are reserving the doctors and our team's time for you to receive the quality of care that you need. Having ALL patients arrive on time enables us to better serve you and other patients. When you agree to your scheduled appointment, we understand that you are omitted as well to arriving on time to help us serve and others in a more timely fashion. Should you need to reschedule an appointment, please provide us with at least 24 hours' notice (one business day) and we will try to accommodate your needs. Patients who repeatedly arrive late for their appointment or cancel appointments with less than 24 hours' notice will incur a $25 broken appointment fee and may 1) be charged a non-refundable deposit when scheduling future appointment, 2) seen only on a "walk-in basis" if the schedule allows, or 3) be dismissed from the practice. In the event of inclement weather, please contact our office prior to arrive if there is any questions as to whether the practice will be open. As a general rule, the practice will be open on days that Wake County Public Schools are operational.

Payment Responsibility

All services provided to you, you dependents, or others for whom you are responsible, you will be responsible for payment for said services. Unless insurance is available or payment is otherwise prearranged, payment is due in full upon check-in at the time of treatment. If treatment is terminated or suspended prior to your treatment being completed, any fees for services already provided shall become due and payable immediately. If the account is not paid as agreed upon and is turned over to collection, you agree that an additional fee will be added to your account balance to cover the costs of collections. Returned checks shall incur $25 return check and the patient will no longer be able to pay with a personal check.

Insurance Claims

If you have dental insurance, please provide the requested insurance information to our team in advance of your appointment. Not doing so may cause you to be required to pay full for treatment at the beginning of your appointment. As a professional courtesy, we attempt to verify your insurance benefits before your appointment and file your insurance claim for you upon completion of treatment. You understand that our practices may differ from those fees allowed by your insurance carrier and that you are ultimately responsible for the full amount of treatment should your insurance company not pay the claim. All insurance claims on your behalf that remain unpaid after 60 days of filing shall become your immediate responsibility to pay.

You acknowledge that you have read and understand these scheduling and payment policies and agree to them as outlined.

______________________________ ______________________

Patient's Signature Date

Jing Zhou., DDS, PA

DENTAL HISTORY

How did you hear about our office?

____

What is the reason for your visit today?

____

Have you ever had a negative dental experience?

____

If yes, please tell us about it so that we can improve your experience with us:

Please circle any of the following that apply to you:

Sensitive teeth	Bleeding gums	Difficulty opening
Loose teeth	Clench/grind teeth	pain or popping jaw
Dentures/partials	mouth ulcers	pain or numbness in mouth
Discolored teeth	crowded teeth	braces/orthodontics

SMILE EVALUATION

Do you like the color of your teeth? ____

Do you like the size and shape of your teeth?__________________________________

Do you like the position of your teeth?_______________________________________

Are you happy with the overall appearance of your smile?________________________

Have you ever had cosmetic dental work?_____________________________________