titusdentistry

PATIENT REGISTRATION

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ______

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

How did you hear about us? ______

Section 3

Emergency Contact

Name: ______

Phone: ______

Relationship to Patient: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

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

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

titusdentistry

Medical History

Date _______________

Name ___________________________________ Date of Birth _____________________

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

Name of your primary care physician: ____

Are you under regular physician's care for a major health condition? Yes No

If yes, please provide your Doctor's name and health condition being treated:

____

Have you ever been hospitalized? Yes No

If yes, please explain ____

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

Medications:

___________________________________ ____________________________________

___________________________________ ____________________________________

___________________________________ ____________________________________

Are you on a special diet? Yes No

Preferred Pharmacy: ____

Do you or have you ever used any of the following:

		Amount	How Often	Started using	Quit
Tobacco	Yes/No	_____________	__________	________	_________
Alcohol	Yes/No	_____________	__________	________	_________
Controlled Substances	Yes/No	_____________	__________	________	_________

Have you ever been told to take antibiotics before dental work? Yes No

If yes why? ____

Which antibiotic do you take? ____

titusdentistry

Medical History

Are you allergic to any of the following? Please circle

Aspirin Penicillin Codeine Acrylic Metal Latex Local anesthetics Other

If yes please explain the type of reaction: ______________________________

Women Only: Pregnant/Trying to get pregnant? **Yes No** Nursing? **Yes No**
Taking oral contraceptives **Yes No**

Do you have or have you had any of the following? Please circle and elaborate below:

Aids/Hiv positive	Epilepsy or seizures	Low Blood Pressure
Alzheimer's disease	Excessive bleeding	Lung Disease
Anemia	Excessive thirst	Mitral valve prolapse
Angina	Fainting spells/dizziness	Parathyroid disease
Arthritis/gout	Frequent Cough	Psychiatric care
Artificial heart valve	Frequent Headaches	Sickle Cell Disease
Artificial joint	Glaucoma	Radiation treatment
Asthma	Hay Fever	Recent weight loss
Blood Disease	Heart Murmur	Rheumatic Fever
Blood Transfusion	Heart Pacemaker	Scarlet Fever
Breathing Problem	Heart trouble/disease	Sinus Trouble
Bruise easily	Hemophilia	Shingles
Cancer	Hepatitis A, B, or C	Spina Bifida
Chemotherapy	High blood pressure	Stroke
Chest pains	Hypoglycemia	Stomach/intestinal disease
Cold Sores/fever blister	Irregular heartbeat	Thyroid Disease
Congenital Heart Disease	Kidney Problems	Tuberculosis Ulcers
Diabetes	Leukemia	Venereal Disease
Emphysema	Liver Disease	

Other: ______________________________

titusdentistry

DENTAL HISTORY

At Titus Dentistry, we have a set of values that are important to us and how we treat our patients. But we don't assume to know what YOU think is important. We know that no two people are the same. We also know that no two mouths are the same. This is where we find out how to best serve your wants and needs. We know that this is one more piece of paper to fill out... but we think it is the most important!

Previous Dentist's Name ____

How often do you have dental examinations? ____

How often do you brush? ____________________ How often do you floss? ____________________

What other dental aides do you use? (toothpick, Water Pik, fluoride, etc.) ______________________________

Do you have any current dental problems? Yes No If yes, please describe:

____

What is your biggest dental concern? ____

Are your teeth sensitive to:	
Hot or Cold?	Yes No
Sweets?	Yes No
Biting or Chewing?	Yes No
Do your gums bleed or hurt?	Yes No
Do you have bad breath?	Yes No
Do you have a family history of gum disease?	Yes No
Have you noticed any loose teeth or a change in your bite?	Yes No
Does food tend to get caught in your teeth?	Yes No

Do you:	
Bite your lips or cheeks regularly?	Yes No
Hold foreign objects in your teeth?	Yes No
Mouth breath while awake or asleep?	Yes No
Have tired jaws, especially in the morning?	Yes No
Snore or have any other sleeping disorders?	Yes No
Are you anxious about dental treatment?	Yes No

Have you ever had:	
Orthodontic treatment?	Yes No
Oral Surgery?	Yes No
Periodontal Treatment?	Yes No
A bite adjustment?	Yes No
A bite splint or mouth guard?	Yes No
A serious injury to the mouth?	Yes No
Have you been diagnosed with a problem with either jaw joint?	Yes No
Does your jaw joint click, pop, or make noise when you open and close?	Yes No
Do you have pain or tenderness in your jaw joint when you open, close, or chew?	
Has your jaw ever locked open or closed?	Yes No
Do you have frequent headaches?	Yes No
If so, how often? ____________________	
Do you clench or grind your teeth OR been told that you do so?	Yes No
Are you satisfied with the appearance of your teeth?	Yes No

Is there anything else about having dental treatment that you would like us to know? Please describe: ______________________

____

____

Financial Policy

Thank you for choosing Titus Dentistry. Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

We offer the following payment options:

- Cash
- Check
- Credit Card
- NO INTEREST[1] or Convenient, low monthly Payment Plans[2] from CareCredit or Alphaeon

We offer a 10% courtesy accounting adjustment to patients who do not have dental insurance and pay for their treatment in full with cash or check at time of service. A 7% discount will be applied if the balance is paid in full at time of service with a credit card.

Please note:

As a courtesy to our patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, it is the responsibility of you, the insured, to ensure adequate coverage at time of service and to ensure proper payment of insurance portions.

If you have Delta Dental insurance coverage you will receive insurance reimbursement checks at your residence and, therefore will be responsible for the full fee at time of service.

For all other insurance policies that allow for assignment of benefits, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

You will also be responsible for reasonable collection fees, attorney's fees, and court costs incurred in any attempt by Titus Dentistry to collect amounts owed.

Your estimated portion will be collected at the time of service.

For procedures that incur a lab fee, 50% will be collected at the start of treatment and the remainder will be due at delivery or completion of the procedure. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Titus Dentistry charges $50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help!

Name: (Please Print) ____ Date ______________

Signature: ____

Name of Patient if different than above: ____

NOTICE OF PRIVACY PRACTICES

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read a copy of Titus Dentistry's Notice of Privacy Practices.

Patient name ____

Signature ____ Date ___________________

If you would like a personal copy of our Notice of Privacy Practices read and print a copy at http://m.titusdentistry.com/notice-of-privacy-practices or contact our office to request a paper copy.

Office Contact Information:

Titus Dentistry - Middletown
705 Norfleet Drive W, Middletown, IN 47356
O: 765-354-4796
middletown@titusdentistry.com

RIGHT OF ACCESS

Please list anyone you would like to give permission to speak to us about your protected medical, dental, or financial information below:

NAME	RELATIONSHIP	CONTACT INFO

My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) is to be disclosed upon the request of the person(s) named above unless amended or revoked by myself.

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
An electronic record, access through an online portal, a hard copy, or verbal communication.

This authorization shall be effective until all past, present, and future periods unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Patient name ____

Signature ____ Date ___________________