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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 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

How did you hear about us? _____

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: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ 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: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

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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

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? _____

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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: _____

_____

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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: _____

_____

_____

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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: _____

705 Norfleet Drive W | Middletown, IN 47356 | (765) 354-4796

middletown@titusdentistry.com

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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 _____