

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Patient Information Address: _____ Address 2: _____ City: _____ State / Zip: _____ Pager: _____ Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____ E-mail: _____ <input type="checkbox"/> I would like to receive correspondences via e-mail. <div style="display: flex; justify-content: space-between;"> Section 2 Section 3 </div>	
Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired Student Status: <input type="radio"/> Full Time <input type="radio"/> 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: _____ <input type="radio"/> Responsible Party is also a Policy Holder for Patient <input type="radio"/> Primary Insurance Policy Holder <input type="radio"/> Secondary Insurance Policy Holder		
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Primary Insurance Information Name of Insured: _____ Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> 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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Secondary Insurance Information Name of Insured: _____ Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> 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? _____

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: _____



Financial Policy

Thank you for choosing Titus Dentistry. Our primary 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.

Payment Options:

We accept:

- Cash, Check, Visa, Mastercard or Discover Card
- NO INTEREST¹ Payment Plans² from CareCredit
- Convenient, low monthly payment plans²

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full with cash or check prior to beginning treatment for treatment plans of \$500 or more.

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 the patient to ensure adequate coverage at time of service and to ensure proper payment of insurance portions.

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 \$30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you obtain the dentistry you want and need!

Patient, Parent or Guardian Signature _____

Date _____

Patient Name (Please Print) _____

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval



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 _____