ATLAS WALK
DENTAL & ORTHODONTICS

New Patient Registration

Name: _____ **P**referred name_____

Address: _____ **C**ity: _____ **Z**ip: _____

Date of Birth: _____ **E**-Mail: _____

Cell phone: _____ **H**ome Phone: _____ **W**ork phone: _____

Social Security Number: _____ **G**ender: _____ **M**arital Status: _____

Emergency Contact: _____ **R**elationship: _____ **P**hone: _____

Do you have Dental Insurance? Yes NO (If yes, please present your card with this form at the front desk)

Employer Name: _____ **O**ccupation:_____

Whom can we thank for inviting you to come to our office: _____

Dental History

Do you require premed antibiotics before dental treatment due to heart condition or artificial joint? Yes No

Reason for your visit today: _____

Previous Dentist: _____ **L**ocation:_____

Date of last dental visit: _____ **D**ate of last cleaning: _____ **D**ate of last x-rays: _____

How often do you brush your teeth? _____ **H**ow often do you floss? _____

What else do you use to clean your teeth? _____

Circle all that apply: **M**y teeth are sensitive to: hot, cold, sweets, chewing, air

Do you have bad breath? Yes No Don't know **D**o your gums bleed or hurt? Yes No

Have your parents had gum disease or tooth loss? Yes No

Do you clench or grind your teeth while awake or asleep? Yes No Don't Know

Do you ever have jaw pain or soreness? Yes No **D**o you snore or have sleep disorders? Yes No Don't Know

Circle all that apply: I have frequent: headaches, neck pain, shoulder aches , Jaw joint pain

Do you wear a nightguard? Yes No **D**o you wear a sleep apnea appliance? Yes No **D**o you smoke? Yes No

Do you chew tobacco? Yes No **D**o you have missing teeth? Yes No **A**re you happy with your smile? Yes No

Are you interested in whitening your teeth? Yes No **A**re you interested in straightening your teeth? Yes No

Do you feel nervous or anxious about having dental treatment? Yes No If yes, why?_____

Please add anything else you feel is important for us to know about you: _____

Consent for Treatment

I authorize Atlas Walk Dental team to take any necessary x-rays, study models, photographs, and other diagnostic aids to make a thorough diagnosis. Upon such diagnosis, I authorize the dentist and/or the hygienist to perform all recommended treatment on which we mutually agree. I agree to the use of anesthetics, sedatives and other medication as necessary, and I fully understand the risks that may be associated. I know that I can ask for a complete recital of any possible complications. I consent to disclose my oral, written, or electronic health records for the purpose of carrying out my treatment and payment. I have read and understand the privacy policy of this office as stated in writing and/or on the website: www.AtlasWalkDental.com. I agree to be responsible for payment of all services rendered to me or my dependants.

Patient Signature: _____ **Date**: _____

Parent/Responsible Party's Signature: _____ **Relationship to Patient**: _____

Atlas Walk Dental And Orthodontics

Medical History Form

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Are you taking any blood thinners including Aspirin?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other Allergies?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

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:

X Date:_____

ATLAS WALK
DENTAL & ORTHODONTICS

Acknowledgment of Office Policies / Privacy Practices Policy

Patient's Name: _____ Date of Birth: _____

Acknowledgment of Broken Appointment Policy
We sincerely value your time and expect you to value ours as well. It is your responsibility to arrive on time for each appointment scheduled. As a courtesy to you, we offer appointment reminder calls, emails, and/or text messaging. You must notify this office at least 48 hours in advance of your appointment if you need to cancel or reschedule. This allows us time to place another patient in your reserved appointment time. We reserve the right to charge a $50 fee for each missed appointment without prior notice.

Acknowledgment of Financial Agreement
We appreciate you allowing us to provide dental care for you and your family. We wish to attract patients and families to our practice that take an active role in their oral health. Because we value our relationship with you and believe the best relationships are based on understanding, we offer these clarifications on methods of payment and insurance reimbursement.

· If you have dental insurance, please bring your insurance card to all appointments and notify us of any changes.
· As a courtesy to you, we will file insurance benefits for you. Many insurance companies will pay our office directly on your behalf. However, some insurance companies may only reimburse you and not our office. If your insurance company will not reimburse our office directly, you will be responsible for the full cost of the visit at the time services are provided.
· Any amount determined not to be covered by your insurance company is payable at the time services are rendered. These fees may include: deductibles, co-payments, and fees not covered by your insurance company.
· We will allow a maximum of 45 days for your insurance company to clear account balances. After this period, any unpaid portions will be due in full by the patient or person financially responsible.
· Methods of payment: Cash, Credit cards, Debit cards, Money orders, and Personal checks (returned check fee of $35).
· Financing Programs: We do not offer in-house financing. However, we do offer a long and short term financing program available through a third party (CareCredit). Please inquire about this for further information regarding this program.
· Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we ESTIMATE insurance coverage to be, and your estimated financial obligation due on the day of the service provided. **This figure is only an ESTIMATE!** Additional billing or refunds may be required. Any differences will be brought to your attention as soon as possible. If a balance remains on your account within 30 days of our billing cycle, a late charge of 1.50% will be assessed each month.
· Financial Obligation: After attempts to collect outstanding funds and a 60 day grace period from the time of service, patients or person financially responsible not fulfilling their obligations can be turned over to collections.

Acknowledgment Of Notice Of Privacy Practices
I (Patient or Legal Guardian) understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy (copy available on our website

www.AtlasWalkDental.com under forms). I understand the Practice will provide current Notice of Privacy Practices / HIPAA Privacy Policy on request.

Acknowledgment of Possible Complications

Even though rare, by state law we are required to make an attempt to inform patients of possible complications, which could result from anesthesia, local anesthesia, and/or sedation.

· Allergic reactions which could require hospitalization
· Cardiac arrest, which could result in brain damage or even death.

It must be understood that these types of complications are extremely rare and every possible precaution will be taken to prevent their occurrence as well as to treat them successfully should they occur.

Other complications, also uncommon, resulting from tooth extractions, periodontal therapy, cyst removal, biopsies, fillings, root canal therapy, crowns, veneers, bridges, etc, are:

· Bleeding heavy enough to stop therapy.
· Injury to adjacent teeth and fillings.
· Post-operative infection requiring additional treatment.
· Possibility of a small piece of root being left in the jaw when its removal would require extensive surgery, or other complications.
· Fracture or breakage of the jaw.
· Post-operative discomfort and swelling which may necessitate several days of home recuperation.
· Stretching of the corners of the mouth resulting in cracking and bruising.
· Nerve injury, sensory and/or motor, adjacent or on the other side of the surgical site, especially underlying teeth resulting in numbness of the palate, lips, tongue, chin, face, or other anatomical structures in the head and neck.
· Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
· Tooth sensitivity, which may require additional treatment.
· Tooth mobility.
· Recession of the gingival (gums).

I,_____, hereby acknowledge that I have read and agree to the information stated in these forms, including Acknowledgment of Possible Complications, Acknowledgment of Broken Appointment Policy, Acknowledgment of Financial Agreement and Acknowledgment Of Notice Of Privacy Practices. I furthermore understand that it is my responsibility to maintain communication with this office by updating my contact information, including phone numbers, addresses, and employment record. By signing below, I agree to all information aforementioned in these agreements and consents.

Patient or Patient Guardian Signature_____ Date_____

Patient or Patient Guardian Signature_____ Date_____

We look forward to working with you to maintain your optimal oral health!
We truly value your trust, thank you for being our patient and we're glad you're here!