DAMIAN SOMMERVILLE, DDS

PATIENT REGISTRATION

First Name **MI** **Last Name** **(Preferred Name)**

Patient is: Subscriber □ Dependent □

Address **City** **State** **Zip Code**

Home Phone/ Cell or Work Phone **EXT** **Email**

Birth Date: _____ **Age:** _____ **Sex: M□ or F□** **Soc Sec:** _____

Drivers Lic: _____ **Marital Status: Married □ Single □ Divorced □ Widowed □ Child □**

Emergency Contact Name: _____ **Number:** _____

Insurance Information:

Carrier Name: _____ **Member ID#:** _____ **Group ID#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

1(800) NUM: _____

Are you the *subscriber?* If yes you may skip this next section. If NOT, please complete the section below: (subscriber Info)

First Name **MI** **Last Name**

Address **City** **State** **Zip Code**

SS Number **Phone Number**

MEDICAL HISTORY

Although as dentist we treat the area in and around the mouth, it is a part of your entire body.
Medical health problems that you have or Medications that you may be taking could be important to your dental health.
Thank you for thoroughly answering the following questions.

Family physician: _____ **Phone Number:** _____

Are you taking any medication now, including regular dosages of aspirin? Yes□ No□
If so, please list name and dosage. _____

Are you aware of having an allergic reaction to any medication or substance? Yes□ No□
If so, please list (e.g. Latex, Penicillin, and Iodine) _____

Have you been under the care of a medical doctor during the past two years? Yes□ No□
If so, for what condition? _____

Have you ever had heart surgery, heart valve or joint replacement, or organ transplant? Yes□ No□
If so, for what and when? _____

Do you require pre-medications (e.g. knee or joint replacement)? Yes□ No□
If so, for what? _____

Do you or have you ever taken Fosamax or any other Bisphosphonate, Zometa, Aredia, Bonovia or Actonel? Yes□ No□

Women: Are you Pregnant? Yes□ No□ Breastfeeding? Yes□ No□ Taking Birth Control? Yes□ No□

Have you seen an ENT(ear, nose, throat doctor)? Yes□ No□

Have you seen a neurologist? Yes□ No□

Please Indicate which of the following you have had, or have at present check "yes" or "no" for each item.

Heart Concerns	Yes□ No□	Neurological Disorders	Yes□ No□	HEADACHES	Yes□ No□
Congenital Heart Disease	Yes□ No□	Osteoporosis	Yes□ No□	Thyroid Disorder	Yes□ No□
Heart Murmur	Yes□ No□	Liver Disease	Yes□ No□	Facial Pain	Yes□ No□
High Blood Pressure	Yes□ No□	Sickle Cell Disease	Yes□ No□	Neck Ache	Yes□ No□
Mitral Heart Valve	Yes□ No□	Asthma	Yes□ No□	Psychiatric Disorder	Yes□ No□
Artificial Heart valve	Yes□ No□	AIDS/HIV	Yes□ No□	Snoring/ Sleep Apnea	Yes□ No□
Pace Maker	Yes□ No□	Stroke	Yes□ No□	Hepatitis	Yes□ No□
Latex Allergy	Yes□ No□	Angina	Yes□ No□	Congested Ears	Yes□ No□
Artificial Joints	Yes□ No□	Ulcers	Yes□ No□	Insomnia	Yes□ No□
Kidney Trouble	Yes□ No□	Tuberculosis	Yes□ No□	Epilepsy/Seizures	Yes□ No□
Radiation/ Chemotherapy	Yes□ No□	Arthritis	Yes□ No□	Diabetes	Yes□ No□

I understand the information above is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge should additional information be needed you have my permission to ask the respective healthcare provider. I will notify Damian Sommerville, DDS and staff of any changes in health or medication.

_____

Patient Signature (If under 18 guardian must sign) **Date**

FINANCIAL /BROKEN APPT

At **Damain Sommerville DDS**, we never want to trade a dental problem for a financial problem. Therefore, we provide a range of payment options for our patients.

- CHECK, DEBIT CARD, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and TRAVELERS CHECKS are all methods of payment.
- **DENTAL PAYMENT PLANS** such as **CARE CREDIT**, **LENDING CLUB**, **MED LOAN**, **ICARE (no credit check required)** are available. We will be happy to assist you in any way.
- **SOMMER SMILES** (in-house financing) we are here to cater to those who do not have traditional insurance.
- **INSURANCE PLANS** We accept many insurance plans and will work with you to maximize all your dental benefits. *(However we make no guarantee of your insurance reimbursement. If we do not receive payment from your insurance you may be held liable for all unpaid insurance portions, unless other arrangements have been made).*
- ***Assignment and Release:*** You, the undersigned, assign directly to **Damian L. Sommerville, DDS** of **Damian Sommerville, DDS General & Cosmetic Dentistry**, all benefits, in any, otherwise the payment to you for services rendered. You hereby authorize the use of your signature on all of your insurance submissions, whether manual or electronic.
- **FLEXIBLE SPENDING ACCOUNTS**
  We accept payments from most FSA and has accounts for approved dental treatments.
- ***PLEASE NOTE***
  We require payment or a financial arrangement before the start of treatment.
  Appointments have been reserved exclusively for you. If for some reason you are unable to make your appointment ***please notify our office staff in a timely manner preferably 24 hours in advance.***
- **THERE WILL BE A $35 FEE FOR ALL RETURNED CHECKS.**

If it would become necessary to have a third party assist Damian Sommerville, DDS in the collection of an account debt, any cost incurred related to that third party collection effort would be advanced to your account.

I have read the financial policy in its entirety and I understand and agree to all its terms and conditions.

Patient (if under 18 guardian must sign) **Date**

DENTAL HISTORY

Damian Sommerville, DDS focuses on providing comprehensive dental for care adults and their families. We strive to deliver care that improves our patient's oral health in a comfortable and relaxing atmosphere.

What is your chief complaint?_____

Does floss shred when you use it? **Yes□** **No□**

Does food pack or catch between your teeth? **Yes□** **No□**

Do you smoke or chew tobacco? **Yes□** **No□**

Do your gums bleed when you brush or floss? **Yes□** **No□**

Does your breath concern you? **Yes□** **No□**

When was your last dental appointment and cleaning? _____

How would you rate your smile (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)

Is there anything you would like to change about your smile? **Yes□** **No□**

Are you interested in learning how we may be able to straighten your teeth? **Yes□** **No□**

Please indicate if you have any of the following concerns (check all that apply)

- □ **My teeth are not in alignment**
- □ **I have spaces I do not like**
- □ **I do not like the color of my teeth**
- □ **Protruding teeth**
- □ **Hidden or missing teeth**
- □ **Old fillings, Veneers, Crowns**
- □ **TMJ discomfort/ jaw pain**
- □ **Overall appearance of my smile**
- □ **Loose teeth**
- □ **Teeth Clenching/ Grinding**
- □ **Difficulty chewing**
- □ **Limited mouth opening**
- □ **Jaw pain**
- □ **Snoring/ Sleep apnea**

What is you reason for trying a new dental office? _____

Are there any additional questions or concerns we should know about? _____

HIPPA FORM

IMPORTANT NOTICE:

Due to new FEDERAL MANDATES called Health Insurance Portability and Accountability Act or HIPPA, healthcare provides are now required to obtain patient consent for the release of private health information.

I give the **DENTAL PRACTICE** of *Damian L. Sommerville, DDS*., Consent to release private health information solely for the benefit of my continued quality healthcare. Healthcare information to be released to my primary care physician, specialist, physicians directly involved in my care, referring dentist, insurance company, or other dental specialist involved in my care. For this purpose private health information is defined as personal information, examination findings, financial estimates, and/or treatment either proposed, underway or completed.

_____

Initials

OR

I do not give the **DENTAL PRACTICE** of *Damian L. Sommerville, DDS*., Consent to release private information, even in the event of any emergency.

_____

Initials

I also give the **DENTAL PRACTICE** of *Damian L Sommerville DDS*., permission to leave reminders and/or pertinent messages at my home and/or answering machine, e-mail or at my place of employment, per my request, and/or to contact me by post-card or letter.

_____

Initials

I understand that any information that has already been disclosed was not protected by this document. I also understand that I may revoke the authorization, in writing at any time.

_____ _____

Signature **Date**