"Experience the Difference"

MIAMI DENTAL SEDATION SPA
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PATIENT REGISTRATION

Patient Information:

Date:_______________

First Name ________________________ MI_____ Last Name _____________________________

Gender: Male_______ Female _________ Title: None___ Mr.___Mrs.___Miss___Ms.___Dr.___

Preferred Name: _____________________________________

Birth Date______________ Social Security__________________

Address: ____

City, State, Zip ____

Cell #_______________ Home# ____________ Work # ___________ Ext____

Email ____

Marital Status Single___Married___Divorced___Widowed___Significant Other___

Appointment Preference None___ AM___PM___ On Short Notice? Yes__ No___

For your convenience, our office will communicate with you via text, email, and will send appointment reminders.

Preferred Dentist _________________________________

Who can we thank for referring you: ______________________________________
Person's Name

How did you learn of our office?

___Google ___Website ___Internet ___Facebook ___Radio ___Banner/Sign ___ Instagram ___ Yelp ___ None

I hereby give Miami Dental Sedation Spa the absolute right and permission to use my photograph images for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation with connection in use of said photographs images. _______. *Initials*

Patient is (Select All that Apply)

Patient_____Policy Holder_____Responsible Party_____

Employed: Full-Time_____Part-Time_____ N/A______ Student: Full-Time_____Part-Time_____ N/A_____
In case of emergency, please contact:
____Phone #_____________________Relation____________________

Who is responsible for your account? Self_____Spouse_____Father_____Mother_____Other_____

Resp First Name __________________________________MI________Resp Last Name _____________________________

Responsible Date of Birth: ______________

Address: ____

City, State, Zip ____

Resp Phone# ____________________________Resp Social Security#__________________________

Resp Employer: ____

Responsible E-mail ____

Do you have Insurance? ***Yes________ No________***

Type of Insurance?: Dental ______ Medical ________

Employer for Primary Insurance____

Name of Primary Insurance Company: ____

Name of Policy Holder (Subscriber) ______________________________________

Relationship to Policy Holder ___Self ___Spouse___Child___Other

Policy Holder (Subscriber)** ID# or Social Security_______________________INSURED Birth Date ______________

Do you have Secondary Insurance? ***Yes______ No________***

Secondary Type? Dental _____ Medical______

Employer for Secondary Insurance_____________________________________

Name of Secondary Insurance Company ____

Name of Secondary Policy Holder (Subscriber) _________________________________

Relationship to Policy Holder ___Self ___Spouse ___Child ___Other

Policy Holder (Subscriber) **ID# or Social Security________________________INSURED Birth Date___________

Dental Information:

Reason for today's visit ____

Are you in pain? Yes __ No __ Since when?_____________________

Please indicate any of the following problems by selecting the corresponding box

Discomfort, clicking, or popping in jaw	___	Lost / broken filling(s)	___
Stained teeth	___	Difficulty closing jaw	___
Red, swollen, or bleeding gums	___	Teeth grinding / clenching	___
Locking jaw	___	Difficulty opening jaw	___
A removable dental appliance	___	Bad Breath	___
Ringing in ears	___	Loose / Shifting teeth	___
Blisters / sores in or around the mouth	___	Broken / chipped tooth	___
Burning tongue / lips	___	Gum Disease	___
Prolonged bleeding from an injury / extraction	___	Toothache	___
Swelling / lumps in mouth	___	Recent infections or sore throat	___
Food caught between teeth	___	Other	___

If other, please explain

____

My teeth are sensitive to Hot __ Cold __ Sweets __ Biting __

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

____

Signature Date

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

____

Signature Date