Patient Registration Form

Personal Information

Patient _____
First Name Initial Last Name

Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Email Address _____ Birthday_____
Sex: M__ F__Marital Status: S__ M__ W__ Sep__ D__ Social Security _____
Full time student Yes_____NO_____Where_____
Can we use your e-mail for electronic correspondence?
E-mail: Yes_____ No_____

Responsible Party _____
First Name Initial Last Name

Emergency Contact
Name _____ Relation _____
Phone number _____Alternate Phone number _____

Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)
Subscribers Name _____ Social Security _____ DOB _____
Insurance Company _____ Group Number _____

Secondary Insurance Information
Subscribers Name _____ Social Security _____ DOB _____
Insurance Company _____ Group Number _____

Referral source
How did you hear about us?_____

Dental Information
Former Dentist:_____ Date of Last Dental X-Rays:_____

Authorization
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Nartker 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 authorize the use of my signature on all insurance submissions.

_____ _____
Signature of patient, parent, guardian, or personal representative **Date**

_____
Please print name Relationship to patient (Please write "self" if not filling out for someone else.)

Splendental
Financial Polices

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. Please feel free to ask us about any questions or concerns you may have. Thank you!

- Insurance**:** At Splendental, we are happy to bill both primary and secondary insurances for you. We feel it is important to explain, however, that **insurance companies cannot guarantee dental benefits to us, and all estimates for your portion due are truly only an estimate.** It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement. Insurance is never a guarantee of coverage. I understand that **posterior restorations are often paid with an "alternate benefit"**, and I will be responsible for the difference.

- Patient Payment: The **patient portion due for services rendered is expected at the time of service** unless *previous* arrangements have been made with the office. We accept cash, checks, and all major credit cards.

- Financing**:** We have financing available through Care Credit. If you have an interest in this option, please consult with the office prior to the date of scheduled treatment.

- No Shows/Missed Appointments**: We require notice to cancel or reschedule an appointment**. If appropriate notice is not given, a charge will be assessed to the patient's account. Fees are required to be paid prior to scheduling a new appointment.

Cancellation fees Per 12-month period				
Amount of time before appointment	**1st occurrence**	**2nd occurrence**	**3rd occurrence**	**4th or more occurrence**
More than 1 week	No Charge	No Charge	No Charge	No Charge
Less than 1 week notice	No Charge	No Charge	No Charge	$50
Less than 48 hours' notice	No Charge	No Charge	$50	$75
Less than 24 hours' notice or missed appointment	No Charge	$50	$75	$100

I have read and understand the cancellation fees

Initial: _____

- Refunds for Unfinished Treatment**:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office.

- Credits on an Account**:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- Collections**:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collection agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding. I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Splendental's staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

Patient Name:_____ Date:_____

Financially Responsible Person:_____

Signature of Financially Responsible Person: _____

SPLENDENTAL INC.

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended your dentist, Dr. Douglas A. Nartker. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain the dentist has addressed all of your concerns to your satisfaction before commencing treatment.

During your course of treatment the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. In the state of Ohio a dental hygienist cannot diagnosis a patient.

- **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus **above the gum line** and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

- **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is schedule the dental hygienist and dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning **below the gum line**, placement of an antibiotic below the gum line or a gross debridement (two part cleaning). If further treatment such as gum surgery and/or extractions are necessary, you will be referred to a Periodontist to schedule a comprehensive periodontal exam and possible treatment. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long term success of dental restoration work.

- **RESTORATIONS (FILLINGS)** A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown or both. Sensitivity is a common aftereffect of a newly placed filling. Occasionally after receiving a filling it may feel high and you may need to return to have the bite adjusted.

- **CROWNS, BRIDGES and VENEERS** It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful chewing on them until the permanent crowns are delivered. If a temporary crown should fall off call the office immediately. The final opportunity to make changes on crowns, bridges or veneers (including shape, fit, size, placement and color) will be done before permanent cementation. In some cases, crowns, bridges and veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown, bridge or veneer is permanently cemented sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleaning procedures may be required and if so will be explained to you by the doctor.

- **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)** Symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw(near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If need for treatment should arise, you will be referred to a specialist, the cost of which is your responsibility.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Allergies/Medication

I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Consent

I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

_____

Patient/Responsible Party Name

_____

Patient/Responsible Party Signature Date

Splendental Inc

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have read and understand the Notice of Privacy Practices for Splendental Inc. (This information is attached to the clipboard for your review, or you may ask for a copy.)

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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