Clear Lakes Dental
Registration Form

Last Name _____ First Name _____ M ____ DOB _____
Address _____ SSN: _____-_____-_____
City _____ State _____ Zip Code _____
Phone Number (_____) _____ - _____ **CALL** or **TEXT** REMINDERS **(circle)** Married Single Child
Email_____ How did you hear about us? _____

Emergency Contact/Phone Number _____Relationship_____

For Minors ONLY(17 years old and under):
Parent/Guardian's Name _____ Phone Number _____
Person Responsible for account(parent/guardian) _____

Medical History: Do you currently have or have had any of the following? (Check all that applies)

- ❑ Acid Reflux
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Chemical Dependency
- ❑ Circulatory Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Problems
- ❑ Hepatitis A B C
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Mental Health Disorders
- ❑ Migraines
- ❑ Pacemakers
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Hemophilia
- ❑ Rheumatic Disorders
- ❑ Sinus Problems
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Cancer: _____
- ❑ Other: _____

Are you allergic to any of the following? (CIRCLE ALL THAT APPLIES)
Penicillin Tetracycline Aspirin Erythromycin Codeine Dental Anesthetics Latex
Other Allergies _____
Medications you are currently taking _____
_____

Are you a smoker/tobacco user? Yes / No

Primary Physician Name/Clinic/Phone Number _____
Are you currently under the care of a physician? Yes / No

WOMEN: Are you pregnant? **Yes / No** If Yes, week #? ___ Nursing? **Yes / No** Taking birth controls? **Yes / No**

Dental History
Last Dental Clinic/Visit_____ Reason for Visit Today _____
Any problems associated with dental work? Yes / No If yes Explain _____

How many times do you brush each day? ____ How many times do you floss a week? ____
Current Dental Health (circle) Excellent Good Fair Poor

Patient OR Parent/Guardian's Signature_____ Today's Date _____

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Clear Lakes Dental Office Policies

We ask for your consideration and cooperation in scheduling your appointments. We are partners in your dental care and we are committed to offering you appropriate care when you need it. Please understand that when you forget, cancel or reschedule your appointment within the proper 24 hour notice, we miss the opportunity to fill that appointment time and clients on our wait list miss the opportunity to receive services. It is mutually understood that if a cancellation is due to circumstances beyond any of control, such as unfortunate incidence or unsafe weather conditions, these emergencies will be considered on an individual basis.
As a courtesy,, our office confirms appointments two days in advance either by phone call or text messaging. We must have confirmation from you no later than 3pm the business day before your appointment. If you are unable to contact us during business hours, please leave a message and we will get back to you.

CONFIRMING YOUR APPOINTMENT IS YOUR RESPONSIBILITY, THANK YOU FOR SUPPORTING OUR CANCELLATION POLICY
IF WE DO NOT RECEIVE CONFIRMATION FROM YOU, YOUR RESERVED TIME MAY BE CANCELLED TO ACCOMMODATE PATIENTS FOR DENTAL EMERGENCIES

Once three (3) appointments have been failed, you will be considered a walk-in only patient. We will see you for your dental needs only when a provider is available.

Arriving 15 minutes or later does not allow time for a full assessment. Therefore, there is no guarantee you will be seen. You may wait for same day availability to be seen.

We require both a government issued Photo ID and insurance card at the time of appointment. For all children 17 and younger we require a parent/guardian government issued Photo ID. We will not be able to provide services to you if it is not available.

Child Supervision **Initial** _____

Children 17 and under must be accompanied by a parent or guardian at all times within the treatment area. Only the child receiving treatment may enter the treatment area unless contained in a stroller or equivalent. Children remaining in the waiting area must be under the supervision of a qualified adult. Failure to adhere to any of the above where a child is not adequately supervised may necessitate termination of treatment and rescheduling of dental procedure.

Assignment of Benefits **Initial** _____

I hereby request payment of authorized benefits to be made directly to **Clear Lakes Dental** for the services provided to me at this facility or any other facility owned and operated by Clear Lakes Dental.

Release of Records **Initial** _____

I hereby authorize **Clear Lakes Dental** to release any information to the insurance company, including but not limited to diagnosis and records of treatment concerning my dental health and treatment.

I understand that **Clear Lakes Dental** will not release any information to anyone unless a release form is completed and returned to the facility by any means (fax, email, courier, etc.)

Privacy Practices Acknowledgment **Initial** _____

I have received the Notice of Privacy Practices (HIPAA) and have been provided an opportunity to review it.

Payment of Account **Initial** _____

I acknowledge and understand that I am responsible for all the charges for services rendered to me. Further, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable amount of time. If, for any reason, any portion of my bill is not paid by my insurance carrier, I agree to make arrangements for prompt payment.

I have read and understand all of the above policies.

Signature: _____ Date: _____