1200 E. Woodhurst Dr. | Building U | Springfield, MO | 65804 Phone: 417.887.3100 | www.ascenddentaldesign.com

ASCEND
DENTAL DESIGN™

New Patient Registration

Please tell us about yourself! Occupation: _____ Employer: _____

Are any of your family or friends our patient(s)? _____

How did you hear about us? Internet search ☐ 417 Magazine ☐ Referral from _____

Insurance provider listing ☐ Other (please specify) _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Social Security Number: _____ Driver's License #: _____

Address: _____ City, State: _____

Zip: _____ E-mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Responsible Party *(if someone other than patient)*

Relationship to Patient: Patient's Parent ☐ Patient's Spouse ☐ Other ☐ _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Social Security Number: _____ Driver's License #: _____

Address: _____ City, State: _____

Zip: _____ E-mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Dental Insurance Information

Policy Holder is: Patient ☐ *(skip to Insurance Company)* Patient's Spouse ☐ Patient's Parent ☐ Other ☐

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Social Security Number: _____ Date of Birth: _____

Insurance Company: _____ Member/Subscriber ID (if have one): _____

Employer Name: _____ City, State: _____

Secondary Dental Insurance Information *(if applicable)*

Policy Holder is: Patient ☐ *(skip to Insurance Company)* Patient's Spouse ☐ Patient's Parent ☐ Other ☐

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Social Security Number: _____ Date of Birth: _____

Insurance Company: _____ Member/Subscriber ID (if have one): _____

Employer Name: _____ City, State: _____

Medical History

Patient Name: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with your dental care. Thank you for answering the following questions.

Do you have a primary care physician?	Yes ☐ No ☐	If yes, who? _____
Are you currently under a physician's care for a medical condition?	Yes ☐ No ☐	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes ☐ No ☐	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes ☐ No ☐	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes ☐ No ☐	If yes, please list them: _____
Do you take (or have you taken) Phen-Fen or Redux?	Yes ☐ No ☐	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes ☐ No ☐	
Are you on a special diet?	Yes ☐ No ☐	
Do you use tobacco?	Yes ☐ No ☐	
Do you use controlled substances?	Yes ☐ No ☐	
Women: Are you…		
… pregnant/trying to get pregnant?	Yes ☐ No ☐	
… taking oral contraceptives?	Yes ☐ No ☐	
… nursing?	Yes ☐ No ☐	

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal ☐ Local anesthetics ☐ Sulfa drugs ☐ Other _____

Do you have (or have you ever had) any of the following? Please check all that apply.

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

If you have ever had any serious illness(es) not listed above, please list it here: _____

By signing this form, you are stating that: To the best of your knowledge, the questions on this form have been accurately answered. You understand that providing incorrect information could be dangerous to your health (or the health of the patient, if you are completing this form on behalf of someone else). It is your responsibility to inform Ascend Dental Design of any changes in medical status.

_____ _____
Signature of Patient Date

or

_____ _____
Signature of Responsible Party Date

_____
Relationship to Patient

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Statement of Financial & Information Policy

Thank you for choosing our office for your dental care. The following is a statement of our financial policy. We ask that you read it prior to your first visit with us.

We will gladly process your insurance claims as a courtesy to you, provided that you give us accurate information. It is your responsibility to inform us of any changes in insurance coverage. **Your insurance coverage is a contract between the policyholder's employer and the insurance company!** All co-pays and co-insurance are due at the time of service. If your insurance fails to pay, you will be responsible for the remaining balance on your account. If you have no insurance, you will need to pay the balance in full, unless prior arrangements have been made. For extensive treatment plans, we offer extended payment plans with prior credit approval through Care Credit and Wells Fargo Health Advantage.

By signing this form, you are consenting to the following:

- examination, diagnostic studies, and treatment as deemed appropriate by Ascend Dental Design,
- release of information concerning that care for insurance purposes or further dental care when necessary,
- payment of authorized benefits to be made on your behalf to Ascend Dental Design for any services furnished by this provider, and
- authorize any holder of dental or medical information about me to be released if needed to determine these benefits or benefits payable for related service.

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The “Notice of Privacy Practices” that are available for your review describes these uses and disclosures in detail.

_____ _____

Signature of Patient Date

or

_____ _____

Signature of Responsible Party Date

_____

Relationship to Patient

ASCEND
DENTAL DESIGN™

We want to get to know you!

Patient Name: _____ Date: _____

We are passionate and dedicated to giving you the best experience possible. By filling out this form, you will help us customize your visits with us. We want to get to know you personally!

1.) About how long has it been since your last dental visit? _____

2.) On a scale of 1 to 10 (with 10 being very) how confident are you with your smile? _____

3.) What are your main concerns?

- ☐ Cleaning/ getting back to health
- ☐ Pain/ sensitivity: where in the mouth? _____
- ☐ TMJ/ jaw problems
- ☐ Cosmetics
- ☐ Invisalign

4.) What type of care would you like from us as your dental family?

- ☐ Comprehensive care; I want to do whatever it takes to keep my teeth and keep them healthy.
- ☐ Proactive care; I want to keep my teeth but only within a certain amount of time and money.
- ☐ Reactive care; I only want to treat something if it is causing me discomfort.

5.) Amenities we offer: please check any below that you would enjoy during some of your appointments.

- ☐ Blanket
- ☐ Bottled water
- ☐ Nitrous (laughing gas)

6.) Is there anything else you'd like us to know about you? _____

_____