Registration Form

Patient Information:

Today's Date_____ Male_____ Female_____ Marital Status_____

Name_____ Date of Birth_____

Address_____ Apt. No._____

City_____ State_____ Zip Code_____

Home Phone No._____ Work No._____

Mobile Phone_____ E-mail Address:_____

_____ ***Please check here if you consent to notifications of upcoming appointments being sent via text to your mobile phone and/or e-mail address***

Social Security No._____ Driver's License No._____

Person to contact in event of emergency and their telephone number:

_____

Responsible Party:

Name_____ Relationship to Patient_____

Address_____ City, State, Zip Code_____
(if different from above)

Home Phone No._____ Work Phone No._____

Social Security No._____ Driver's License No._____

Insurance Information:

Employee Name_____ Employer Name_____

Insurance Co._____ Group No._____

Employee Date of Birth_____ Employee Social Security No._____

Referred By:

How did you hear of us or whom may we thank for referring you to our office:

_____

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives and other medication, as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I acknowledge that it is the policy of Prosthetic Dentistry of Mt. Lebanon, PC to use scanned images of all paperwork pertaining to my file, including all paperwork I have completed and signed, in place of the original documents. I hereby consent to the validity of these scanned images as originals. I understand that the hard copies of these records will be destroyed by Prosthetic Dentistry of Mt. Lebanon, PC once they have been scanned into my patient file in their computer system.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) and any expenses such as attorneys' fees, if engaged, may be added to my account. I understand that all payments are non-refundable.

Patient or Responsible Party_____ Date_____

(PLEASE SIGN HERE)

PATIENT NAME

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? …….. Yes No
   If yes, for what?_____
   Physician's Name_____ Phone_____

2. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ……. Yes No
   If yes, please list:_____
   _____

3. Have you been diagnosed with Sleep Apnea and/or suffer from loud, chronic snoring? Yes No

4. Have you taken any medication or drugs the past two years? …… Yes No

5. Have you lost or gained more than 10 pounds in the past year?..... Yes No

6. Are you taking any medication, drug or pills now? …… Yes No
   If yes, please list: _____
   _____
   _____
   _____
   _____

7. Indicate which of the following you have had or have at the present time. Circle "Yes" or "No" to each item.

Heart Surgery/Disease……	Yes No	Ulcers……	Yes No	Hepatitis A (Infectious) ..……	Yes No
Chest Pain……	Yes No	Diabetes……	Yes No	Hepatitis B (Serum)…….……	Yes No
Congenital Heart Disease…..	Yes No	Thyroid Problems……..…..	Yes No	Hepatitis C……..…..	Yes No
Heart Murmur…….....	Yes No	Glaucoma…….....	Yes No	Venereal Disease…….....	Yes No
High Blood Pressure……...	Yes No	Contact Lenses……...	Yes No	A.I.D.S…….....	Yes No
Mitral Valve Prolapse……...	Yes No	Emphysema……..…..	Yes No	H.I.V. Positive……..…..	Yes No
Artificial Heart Valve……	Yes No	Chronic Cough……	Yes No	Cold Sores/Fever Blisters……	Yes No
Heart Pacemaker……	Yes No	Tuberculosis……	Yes No	Blood Transfusion……..……	Yes No
Rheumatic Fever……	Yes No	Asthma……..……	Yes No	Hemophilia……..……	Yes No
Arthritis/Rheumatism……...	Yes No	Hay Fever……..……	Yes No	Sickle Cell Disease……..	Yes No
Cortisone Medication……...	Yes No	Latex Sensitivity……..…..	Yes No	Bruise Easily……..…..	Yes No
Swollen Ankles……..	Yes No	Allergies or Hives……	Yes No	Liver Disease……..…..	Yes No
Stroke……	Yes No	Sinus Trouble……..……	Yes No	Yellow Jaundice……	Yes No
Diet (Special/Restricted)……	Yes No	Radiation Therapy……..……	Yes No	Epilepsy or Seizures…….	Yes No
Artificial Joints……..	Yes No	Chemotherapy……..	Yes No	Fainting or Dizzy Spells……..	Yes No
Kidney Trouble……..	Yes No	Tumors……..……	Yes No	Neurological Disorders…….	Yes No
Lyme Disease……..	Yes No	Bleeding Disorder……	Yes No	Nervous/Anxious……..	Yes No
Sjogren's Syndrome……	Yes No	Sleep Apnea……	Yes No	Psychiatric/Psych Care……	Yes No
Autism……..	Yes No	ADHD……..……	Yes No		

8. Do you have or have you had any disease(s), condition(s) or problem(s) not listed?..... Yes No
   If yes, please list:_____
   _____

9. What is your height? _____ (feet/inches) ⟶ 9. What is your weight? _____ (pounds)

10. **Women:** Are you: **Pregnant?** Yes, ____ (months) No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____ **Date**_____

(PLEASE SIGN HERE)

OFFICE USE ONLY: UPDATED MEDICAL HISTORY REVIEWED BY THE FOLLOWING TREATING DENTIST:

Dentist's Signature:_____ **Date**_____

PATIENT NAME

DENTAL HISTORY

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-Rays_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____

Address_____ State_____ Zip_____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No

If yes, please describe:_____

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you notice any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sore, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?_____

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe:

_____

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause:

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Local or Dental Anesthesia Allergy?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, nails, fingernails)?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe:_____

_____

OFFICE USE ONLY: UPDATED MEDICAL HISTORY REVIEWED BY THE FOLLOWING TREATING DENTIST:

Dentist's Signature:_____ **Date**_____

Prosthetic Dentistry of Mt. Lebanon, PC

PATIENT FINANCIAL POLICY

Effective September 1, 2025

PAYMENTS:

To maintain an environment that focuses on the best possible dental care, our office has established a straightforward financial policy that simplifies patient's payments.

- The patient takes responsibility for the costs of his/her dental care.
- The patient arranges for payment before treatment begins.
- Payment is due at the time of service. When applicable, our office will fill out forms ready for submission of claims to all dental insurances carried by the patient. For patient co-payments and procedures not covered by insurance, the patient personally and directly makes full payment to our office at the time dental services are rendered.
- All payments made by patient and their insurance company are non-refundable, regardless of the reason.
- We can help our patients obtain interest-free financing with CareCredit.

KEEPING APPOINTMENTS:

We believe our patients agree that time is valuable to everyone. We ask that our patients respect this and do all they can to keep appointments and be on time. **If you are unable to keep your appointment, a 24-hour notice is required.** If you fail to keep your appointment, you will be charged $50.00 for every half an hour of total appointment time scheduled.* We understand that emergencies happen; however, if cancelling appointments becomes a habit we will have no choice but to dismiss you as a patient. *(*Fee must be paid before scheduling future appointments).*

CO-PAYMENTS AND COLLECTION OF FEES:

Certain dental procedures might require a co-payment and/or deductible and/or office visit fee to be paid by the patient based on the benefit details of their insurance policy. You will be notified if there is a co-payment and/or deductible and/or office visit fee for your treatment. Payment options (if applicable) will be discussed before we begin your treatment. In the event that any outstanding balance is not paid within thirty (30) days from the date of commencement of your treatment, a 1.5% monthly finance charge will be added to the outstanding balance and compounded monthly until the total amount has been paid in full. If failed attempts to collect any outstanding balance result in our taking collection action against you, an additional 33 1/3% of the total amount due will be assessed for the costs of collection. Once you have consented to treatment, it is considered a "promise to pay" us the agreed upon fee in full. Once full payment is received, we will begin your treatment. You will be responsible for payment of the total amount of your treatment plan, regardless if you choose not to complete it. All payments made by you and/or your insurance company are non-refundable. **Any office visit fees, co-payments, and any fees not covered by your insurance company are your responsibility to pay. If for any reason your insurance policy is not in effect at the time of your appointment (i.e., a retroactive cancellation after treatment has been completed, etc.), you agree to pay any and all outstanding fees that your insurance carrier did not pay.**

LAB FEES:

Some dental insurance plans cover laboratory fees. If your dental insurance plan does not cover the cost of laboratory fees or if you are a self-paying patient, you will be responsible for payment of all laboratory costs (in-house and outside labs). These charges will be added to your account and will appear on your statement.

METHODS OF PAYMENT:

We accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit. If a payment is returned by your financial institution for any reason, you will be charged a fee equivalent to the amount posted in our office at the time the payment is returned. All CREDIT CARD payments are subject to a service fee of 3.0% of the total sale.

PLEASE READ CAREFULLY AND SIGN:

I agree to pay indicated fees at the time dental services are rendered. I agree to abide by the protocol for missed appointments. If services are terminated and copies of my chart are requested to be furnished to myself and/or another dental provider, I agree to pay, in advance, for all copying and delivery fees as determined by Prosthetic Dentistry of Mt. Lebanon, PC. I grant my permission to this office to telephone me at home or work to discuss matters related to this form.

I have read this entire form and agree to its content. This financial policy supersedes any other financial policies I have previously signed with Prosthetic Dentistry of Mt. Lebanon, PC.

Patient Name: _____ Signature: _____

(PLEASE PRINT NAME) ***(SIGNATURE OF RESPONSIBLE PARTY)***

Relationship to Patient: _____ Date: _____

NOTICE OF PRIVACY PRACTICES – Page 1 of 2

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. At any time, you may request to receive a copy of this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will maintain a scanned copy of the original Notice in your file which will serve as an original document for the purposes of record-keeping and reproduction. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/01/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payments for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **To Your Family and Friends:** We must disclose your health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

_____ PLEASE INITIAL HERE TO ACKNOWLEDGE THAT YOU HAVE READ OUR PRIVACY POLICY
THEN PROCEED TO PAGE 2 FOR ACKNOWLEDGEMENT OF RECEIPT AND SIGNATURE…

NOTICE OF PRIVACY PRACTICES – Page 2 of 2

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT. HOWEVER, BECAUSE WE ARE REQUIRED TO NOTIFY YOU OF OUR PRIVACY POLICY, WE ARE ALSO REQUIRED TO INDICATE YOUR REFUSAL TO SIGN.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
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 us from obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify)

_____

_____