Please complete the following confidential patient registration forms using your keyboard and mouse. Please then print, sign, and then mail, fax, or bring the forms with you to your next appointment. Our mailing address is: Michael J. Uzelac, DDS, 850 Marsh Street, Suite A, Valpariaso, IN 46385. Our fax number is (219) 548-8842.

Welcome to Our Office!

Our Mission Is: To serve each patient and team member with integrity, respect and kindness. We are committed to working in collaboration with each individual to accomplish a comprehensive examination. We offer our patients the highest standards of excellence in preventative, restorative and esthetic services.

Written collectively by your dedicated Dental Team at Dental Arts Group

Patient Information

Name: Mr. ☐ Mrs. ☐ Ms. ☐ ________________ *Last* ____ *MI* __________ *First* Today's Date _________

What would you like us to call you? (preferred name) ______________________

Street Address ______________________________________

City ______________________ State ______ Zip Code ____________

Phone # (Home) ______________ (Work) ______________ (Cell) ______________

E-mail Address ______________________________

How would you like us to confirm your appointments:

E-mail ☐
Phone ☐
Not necessary ☐

Social Security Number ______________________ Date of Birth ______________

Whom may we contact in case of emergency?

Name ______________________ Phone # ______________

Whom may we thank for referring you? ______________________

Tell Us About You....

The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you tick. Please click in a square and place an X along each line indicating which way your opinion or preference leans.

I like to be presented with fewer options											I like to be presented with more options
I tend to look at the details											I tend to look at the big picture
I prefer long-lasting solutions that may cost more											I prefer more temporary solutions at lower cost
My insurance largely determines the extent of my care											I largely determine the extent of my care

Primary Insurance and/or Person Responsible for Payment

Name Mr. Mrs. Ms. ______________________ ____ ______________
☐ ☐ ☐ *Last* *MI* *First*

If different from patient information:

Street Address ______________________________

City ______________________ State ______ Zip Code __________

Phone # (Home) ______________________ (Work) ______________________

Social Security Number ______________________ Date of Birth ______________

Employer Name ______________________________

Employer Address ______________________________

Occupation ______________________________

Insurance Company ______________________________

Insurance Phone Number ______________________

Group Number ______________________ Contract Number ______________________

Have you used your insurance this year? ☐ yes ☐ no

Spouse and/or Secondary Insurance

Name Mr. Mrs. Ms. ______________________________
☐ ☐ ☐ *Last* *M/* *Firs t*

Street Address ______________________________

City ______________________ State ______ Zip Code __________

Phone # (Home) ______________________ (Work) ______________________

Social Security Number ______________________ Date of Birth ______________

Employer Name ______________________________

Employer Address ______________________________

Occupation ______________________________

Insurance Company ______________________________

Insurance Phone Number ______________________

Group Number ______________________ Contract Number ______________________

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, however, all charges for services and collection cost for untimely payments are ultimately my responsibility.

Signature (parent's if minor) X ______________________________ Date ______________

Medical History

Today's Date __________

Patient Name: Mr. Mrs. Ms. ______________________ ____ _________ Date of Birth __________

☐ ☐ ☐ *Last* *M/* *Firs t*

Street Address: ____

City: ________________________ State______ Zip Code ___________

Phone # (Home) ________________________ (Work) ________________________

New Dental Insurance? ________________________

General Health: ☐ Excellent ☐ Good ☐ Fair Date of last physical ____________

Physician's Name ________________________ Phone ________________________

Are you under current medical treatment? .... ☐ yes ☐ no

If yes, please explain: ____

Are you currently taking any medications or herbal supplements? .... ☐ yes ☐ no

If yes, please list medications and herbal supplements: ________________________

____

Do you have any allergies or adverse reaction to drugs? .... ☐ yes ☐ no

If yes please list: ____

____

Are you on a special diet? .... ☐ yes ☐ no

Have you lost or gained more than 1 0 pounds in the past year? .... ☐ yes ☐ no

Do you use any form of tobacco? .... ☐ yes ☐ no

What Brand? ________________________ How Much? ________________________

Are you interested in quitting? .... ☐ yes ☐ no

Women - (Please check)

Are you: Pregnant ☐ yes Nursing ☐ yes On hormone therapy ☐ yes On birth control medication? ☐ yes

Has a Physician ever informed you that you have or have had any of the following?

Condition			Condition		
Rheumatic Fever	☐ yes	☐ no	Respiratory Disease	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no	Intestinal Disease	☐ yes	☐ no
Mitral Valve Prolapse	☐ yes	☐ no	Cancer	☐ yes	☐ no
Other Heart Ailment	☐ yes	☐ no	Chemo/Radiation Therapy	☐ yes	☐ no
Artificial Joints	☐ yes	☐ no	Liver Disease	☐ yes	☐ no
HIV or Aids	☐ yes	☐ no	Kidney Disease	☐ yes	☐ no
Hepatitis	☐ yes	☐ no	Major Operations	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	Diabetes	☐ yes	☐ no
High Blood Pressure	☐ yes	☐ no	Stroke	☐ yes	☐ no
Fainting Spells	☐ yes	☐ no	Psychological/		
Epilepsy	☐ yes	☐ no	Psychiatric Treatment	☐ yes	☐ no
Head Injuries	☐ yes	☐ no	Caffeine Dependency	☐ yes	☐ no
Blood Disorder	☐ yes	☐ no	Drug/Alcohol Dependency	☐ yes	☐ no
Latex Sensitivity	☐ yes	☐ no	Organ Transplant	☐ yes	☐ no

For Office Use Only

Changes in medical history or medications:

____

________________________ Date ____________ Patient's Initial _____

Changes in medical history or medications:

____

________________________ Date ____________ Patient's Initial _____

Dental History

When was your last cleaning and examination? __________ Your last dental x-ray taken? __________

Who was your previous dentist? ________________________________ Phone ________________

What influenced you to change dentists? ____

What is your immediate dental concern? ____

Please check if you have, or ever had the following:

1. Unfavorable dental experiences ☐
2. Dental fears ☐
3. Preference for no dental anesthetic ☐
4. Problems with effectiveness or bad reactions to dental anesthetic ☐
5. Orthodontic treatment (braces) ☐ When? ________________
6. Periodontal (gum) treatment ☐ When? ________________
7. Bleeding gums ☐
8. Habitual chewing of hard substances, e.g., ice, popcorn kernels ☐
9. Part of your mouth is sensitive to temperature ☐
10. Lumps or bumps on head or neck ☐
11. Dry mouth ☐
12. Do you have a sugar or soda pop habit? ☐
13. An unpleasant taste or odor in your mouth ☐
14. Viral infection or cold sores ☐
15. Jaw problems (temporomandibular joint) ☐
16. Difficulty opening your mouth widely ☐
17. Stiff or sore facial muscles ☐
18. Awaken with an awareness of your teeth or jaws ☐
19. Tension headaches ☐
20. Clench or grind your teeth ☐
21. Jaw clicking or popping ☐
22. How often do you brush? ____________
23. How often do you floss? ____________
24. Other oral health aids: ____________
25. Wearing any oral appliances? ____________
26. Wearing any removable teeth? ____________

How important is it for you to keep the rest of your teeth for the rest of your life? (check one):

Not important 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Very Important

How would you rank your smile? (check one):

Unpleasant 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Beautiful

Please share with us any goals or ideas you may have regarding your oral health or smile:

____

____

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Signature (parent's if minor) X ________________________________ Date ______________

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____________ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care

3. I agree to the use of anesthetics, 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.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature ______________________________ Date _____________ Witness __________________

Parent/Responsible Party's Signature ______________________________ Relationship to Patient ____________

New Patient Insurance Registration Form

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turn around.
3. Researching your dental insurance plan to advise you of estimated benefits available to you.
4. Re-filing your insurance a second and final time at 30 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, Please sign the "assignment of benefits" below to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Michael J. Uzelac to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Michael J. Uzelac. I understand I am responsible for any unpaid balance.

_________________________________ Date _____________

Signature of Patient/Insured