OSORIO
DENTAL GROUP
60 Federal Street Boston, MA 02110 Phone: (617) 423-6165 Fax: (617)426-0006

PATIENT REGISTRATION

(Please Print)

New Patient ☐ Update of Information ☐	Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Preferred Name	Sex: ❑ M ❑ F	Referred By:
Birthdate / /	Social Security no.:	Primary Phone no.: ( )	❑ Mobile ❑ Home		
Street Address:	City, & State:	Zip Code:			
P.O. box:	Alternate Phone no.:	Email			
Occupation:	Employer:	Employer phone no.: ( )			

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the Front Desk.)

Person responsible for account:	Birth date: / /	Address (if different):	Phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance:	Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

Contact Name & Address	Relationship to patient:	Primary Phone no.: ( )	Alternate Phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims.

X

Patient/Guardian signature *Date*

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FINANCIAL POLICY

Thank you for choosing Osorio Dental Group as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, Mastercard, Visa, Discover, and Amex. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary to our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do you have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, and your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, or credit card at the time we provide service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your payment is denied, you will be responsible for paying the full amount at the time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid/ Our office will not, however enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

IMPORTANT NOTICE: BROKEN APPOINTMENT POLICY

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all our patients honor their reserved dental appointments. Failure to do so deprives other patients from receiving needed dental care in a timely fashion. So that our dentists, our staff, and other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates a $65.00 fee for any patient that does not give at least a 24 hour notice for any cancellations or rescheduling. This fee is to be paid before any new appointments are made.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance and that I will be charged for a broken appointment.

By signing below, you are authorizing, us to call you at any number you provide including calls to mobile or similar devices for any lawful purpose. You agree to any fees or charges that may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

X_____ _____

Patient/Guardian Signature Date

_____

Print Name

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DENTAL HISTORY

Please **ONLY** check the following problems **THAT APPLY TO YOU:**
-Sensitivity (hot, cold sweet, pressure)
-Headaches, earaches, neck pain☐
-Jaw joint pain/TMJ pain or clicking☐
-Teeth or fillings breaking☐
-Grinding or clenching teeth☐
-Bleeding, swollen, or irritated gums☐
-Loose, tipped, or shifting teeth☐
-Bad Breath☐

Do you have or have you had any of the following?
-Dentures☐
-Partial dentures☐
-Braces☐
-Periodontal (gum) treatments☐

Please share the following dates:
-Your last cleaning ____ /____
-Your last oral cancer screening ____/_____
-Your last complete X-Rays ____/_____

(Please Circle **Yes or No**)
If you could whiten your teeth for a cost anyone could afford, would you do it? Yes or No
Do you smoke or use chewing tobacco? Yes or No
How often? _____

(Check **ONLY** those that apply)
If I could change my smile, I would
-Make it whiter ☐
-Make it straighter ☐
-Close spaces ☐
-Replace metal fillings with tooth colored restorations ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

Would you ever consider invisalign treatment or botox for grinding or cosmetic reasoning? Yes or No

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today?_____

MEDICAL HISTORY

Please **ONLY** check the following problems/conditions **THAT APPLY TO YOU**:

AIDS	☐	Emphysema	☐	Jaundice	☐	Steroid Medication	☐
Allergies (seasonal)	☐	Epilepsy	☐	Kidney Disease	☐	Stomach Problems	☐
Anemia	☐	Excessive Bleeding	☐	Liver Disease	☐	Stroke	
Angina (Chest Pain)	☐	Fainting	☐	Low Blood Pressure	☐	Thyroid Disease	
Arthritis	☐	Glaucoma	☐	Nervousness/Depression	☐	Tuberculosis	
Artificial Heart Valve	☐	Heart Conditions	☐	Pacemaker	☐	Ulcers	
Artificial Joints	☐	Heart Lesions *(Congenital)*	☐	Pregnant Currently	☐	Venereal Diseases	
Asthma	☐	Heart Murmur	☐	Radiation *(head/neck)*	☐	Other *(Please fill in below)*	
Blood Disease	☐	Heart Surgery	☐	Respiratory Problems	☐		
Bruise Easily	☐	Hepatitis A	☐	Rheumatic Fever	☐		
Cancer	☐	Hepatitis B	☐	Rheumatism	☐		
Chemotherapy	☐	Hepatitis C	☐	Scarlet Fever	☐		
Diabetes	☐	High Blood Pressure	☐	Seizures	☐		
Diziness	☐	HIV Positive	☐	Sinus Problems	☐		
Drug Addiction	☐	HPV *(Human Papilloma Virus)*	☐	Sleep Apnea	☐		

(If none apply please check here)☐

Please **ONLY** check the following problems/conditions **THAT APPLY TO YOU**:

Heart Valve Replacement/Valve Repair	☐	Heart Transplant w/ Valve Disease	☐
Congenital Heart Disease	☐	Total Hip/Joint Replacement	☐
Infective Endocarditis	☐	Cardiac Shunt	☐

(***If none apply please check here***)☐

Initials _____ (I have answered all the health questions to the best of my knowledge).

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MEDICAL HISTORY (CONT.)

Please **ONLY** check the medication in which you've had an allergic reaction to

Aspirin	☐	Percodan	☐	Tetracycline	☐	Valium	☐
Darvon	☐	Latex	☐	Codeine	☐	Penicillin	☐
Nitrous Oxide	☐	Local Anesthetic	☐	Erythromycin	☐	Sulfa	☐

(***If none apply please check here***)☐

Check **ANY** medications you have ever taken

Actonel	☐	Zometa	☐
Aredia	☐	Boniva	☐
Fosamax	☐	Herbal	☐
Reclast	☐	Supplements	☐

Other Medications in which you had an allergic reaction to: _____

If you answered yes to any of following above please describe reaction.

_____

_____

_____

Initials _____ (I have answered all the health questions to the best of my knowledge).

Are you under a physician's care, if so what for? _____

_____

List **ALL** medications you are currently taking? _____

_____

Primary Care Physician _____ Phone Number _____

Consent:
The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

X_____ _____ _____

Patient/Guardian Signature **Date** **Doctor Signature**