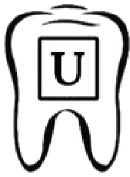

UNIVERSITY SQUARE
DENTAL ASSOCIATES

New Patient Registration

**indicates a required field*

Full Name * ______________________________ Date Of Birth * ______________

Preferred Name ____________________ Pronouns ____________

Address/ Street * ______________________ City ____________ State _______ ZIP _______

Billing Address * ______________________ City ____________ State _______ ZIP _______

Email * ___________________________ Social Security Number * ____________________

please provide, often required to bill insurance

Phone Number * ____________________ Alt. Phone Number ____________________

* Emergency Contact ________________________ ________________________

Name/Relationship Phone Number

Dental Insurance Coverage

skip if you do not have dental insurance

Policy Holder Full Name* ____________ Policy Holder Date of Birth* ____________ Member ID #* ____________

Policy Holder Address* ____________ Policy Holder SSN* ____________ Policy Holder relationship* ____________

Employer Name* ____________ Dental insurance company* ____________ Group # * ____________

Please provide a copy of your dental insurance card to the front desk

Pictures of the front and back of your card can be emailed to: **frontdesk@usquaredental.com**

Authorized Persons

I acknowledge that I have received a notice of privacy practices from University Square Dental.
I authorize the release of dental health information to the following people:

Name ____________ Relationship ____________ Phone Number ____________

Name ____________ Relationship ____________ Phone Number ____________

I give my consent to the release of information to the above mentioned persons and certify that the above information is complete and accurate.

***Signature** ______________________________ ***Date** ____________

How did you hear about our practice? ___________________________

WE ARE ALWAYS ACCEPTING NEW PATIENTS!

The highest form of a compliment is referring a new patient to us! Refer a new patient to our practice and receive **$25** towards your dental treatment! This is an unlimited offer and does not expire.
Ask us today for a referral card and send your friends our way!

Consent for Treatment and Financial Agreements

I the undersigned, hereby authorize University Square Dental to take radiographs, study models, photographs, records or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs. I also authorize University Square Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent University Square Dental to employ any such assistance as they deem appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations render: to my insurance company, consulting professionals and others I approve.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney’s and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. Last minute cancellations and missed reservations will be subject to a charged fee of $45.00. **To avoid this charge, please contact our office within 48 hours of your reservation to make changes to your appointment(s).** We do understand that, on occasion, last minute things do occur. If we both take our commitment to each other seriously, these issues are often avoidable.

I certify that the information given is correct and current. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independently of insurance reimbursement. Certain reservations may require payment in full unless approved arrangements have been made. I certify that I have also received a copy of the privacy policy.

PAYMENT DISCOUNTS Payment is required the day of service and for our uninsured patients we offer a 15% discount for cash when payment is received on the day of service. We accept VISA, Mastercard, American Express, Discover.

I certify that the above information is complete and accurate.

_______________________________________ _______________

***Signature** ***Date**

Medical History

Dental professionals primarily treat the area in and around your mouth. The mouth is part of your entire body and health problems that you may have and/or medication you may be taking could have an interrelationship with the dental care you will receive. Please answer the following questions. Thank you!

Patient Name ______________________ Date Of Birth ____________ Today's Date ____________

Who is your medical doctor or clinic? ______________________

Question	Y	N	If yes, please explain
*Have you ever been hospitalized or had a major operation?	☐	☐	______________
*Have you ever had a serious head or neck injury?	☐	☐	______________
*Do you use prescription pain medications or recreational drugs?	☐	☐	______________
*Do you take or have you taken Phen Fen or Redux?	☐	☐	______________
*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates?	☐	☐	______________
*Do you use chewing, smoking tobacco or e-cigarettes?	☐	☐	______________
*Are you on a special diet?	☐	☐	______________
*Are you pregnant? How many months? Nursing?	☐	☐	______________

***Please provide a complete list of all medications:**

______________ ______________ ______________ ______________

*Please indicate **Yes** or **No** to the following:

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

☐ **NO TO ALL ABOVE**

*Have you ever had an illness NOT listed above? If yes, please explain. ______________________

***Are you allergic to any of the following:**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ OTHER: ____________

Preferred Pharmacy: ______________________ Pharmacy Phone Number: ______________________

______________________________ ______________

***Signature** ***Date**

I certify the above information is complete and accurate. It is my responsibility to inform the office of any changes in medical status.

Dental Health History

Patient Name ______________________ Date Of Birth __________ Today's Date __________

*** How would you like to hear your dental health information?**

☐ Bottom Line ☐ Brief Detail ☐ Lots of Detail

*** If you could change one thing about the look/feel of your smile, what would it be?**

☐ Replace Missing Teeth ☐ **Whiter Teeth** ☐ **Straighter Teeth** ☐ Replace Mismatched Crowns ☐ **Repair Chipped Teeth** ☐ **I don't want to be embarassed smiling**

*** How often do you brush and floss?**

Please mark the correct options for your brushing and flossing schedule (ex. Brush: 2x, daily)

	1x	2x	3x	Day	Week	Month
Brush	☐	☐	☐	☐	☐	☐
Floss	☐	☐	☐	☐	☐	☐

Date of last dental visit: ______________ **Date of last dental x-rays:** ______________

Previous Dentist (name, location, phone number) ______________ ______________ ______________

*** Please check the following items you have:**

☐ **Fixed Bridge** ☐ **Partial Denture** ☐ **Dentures** ☐ **Dental Implants** ☐ **Gum Surgery** ☐ **Jaw Surgery**

☐ **Root Canal** ☐ **Same Day Crown (Cerec)** ☐ **C-PAP Machine/Sleep Appliance** ☐ **Veneers** ☐ **Orthodontics (braces)**

* Please indicate **Yes** or **No** to the following:

	Y	N		Y	N		Y	N
Sensitivity to hot, cold or sweets	☐	☐	**Loose teeth**	☐	☐	**Clicking/popping of jaw**	☐	☐
Sore or bleeding gums	☐	☐	**Toothaches**	☐	☐	**Cold Sores/Oral Lesions**	☐	☐
Periodontal Disease	☐	☐	**Snoring**	☐	☐	**Growth(s) lesions in mouth**	☐	☐
Missing Teeth	☐	☐	**Swollen Glands**	☐	☐	**Difficulty opening/chewing**	☐	☐
Offensive/Bad Breath	☐	☐						

***What matters most to you in your overall dental health:** ______________________________

____

____

***How do you feel about your dental treatment?** ☐ Relaxed ☐ Anxious ☐ Major Phobia

______________________________ ______________

***Signature** ***Date**

I certify the above information is complete and accurate.

Consent for Release of Information

Patient Name ______________________ Date of Birth ______________

Patient Phone ______________________ Patient Email ______________________

Information to be Released to:

University Square Dental Associates
Email: frontdesk@usquaredental.com
Phone: (608) 256-6839 Fax: (608) 268-6840

Information to be Released from:

______________________ ______________________
Dental Office or Dentist Name Phone Number

______________________ ______________________
Email Fax

I hereby authorize the release of the information contained in my dental records which may contain personal and confidential information.

I release ______________________ from any legal responsibility that may result
(Previous dental office)
from this authorization.

Authorization is valid for 90 day and may be revoked in writing any time prior to 90 days by notifying the releasing party.

______________________________________ ______________
Signature * **Date** *

____
Relationship to patient *if patient is a minor*