T. LANCE COLLIER, DMD, LLC

Family Practice *of* General Dentistry

NEW PATIENT REGISTRATION

Please provide us the following information.

GENERAL INFORMATION

Name_____ Preferred:_____

Address_____

City_____ State_____ Zip_____

Email Address_____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ FAX (_____)_____

Date of Birth_____/_____/_____ SSN_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

EMPLOYMENT INFORMATION

Employer_____ Occupation/Job Title_____

Employer's Address_____

SPOUSE INFORMATION – OR – PARENT/GUARDIAN (if patient is a child/minor)

Spouse's Name_____

Employer_____ Work Phone (_____)_____

SSN_____ Date of Birth_____/_____/_____

RESPONSIBLE PARTY. WHO IS RESPONSIBLE FOR YOUR CHARGES TODAY?

Responsible Party's Name_____

Address_____

City_____ State_____ Zip_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name_____

Relationship to Patient_____ Phone No.(_____)_____

PHYSICIAN CONTACT INFORMATION

Name of Primary Physician or Clinic_____

Address_____ Phone No. (_____)_____

Date of Last Medical Exam_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

□ INTERNET □ MAGAZINE AD □ FRIEND □ PHONEBOOK □ INSURANCE CARRIER

□ OTHER: _____

INSURANCE INFORMATION

Insurance Co._____

Name of Insured_____

Individual No._____ Group No._____

Insured's Date of Birth_____/_____/_____ Insured's SSN_____

Relationship to Insured_____ Insured's Employer_____

APPOINTMENT REMINDERS & ONLINE ACCOUNT ACCESS

APPOINTMENT REMINDER, CONFIRMATION, LATE ARRIVAL AND CANCELLATION POLICIES

As a complimentary service, our office utilizes an automated system for appointment reminders and confirmations. The system is structured using emails, text messages, and automated phone calls. This works well if you are "on-the-go" and prefer to have Appointment Reminders electronically delivered to your Inbox or Mobile Phone. Appointments can be confirmed by clicking a link in reminder emails, by responding with the letter "C" to text reminders, or by following instructions given during automated phone calls. Our office will also contact you by phone directly to remind you of your appointment.

Your appointments are specifically reserved for you. ***Please plan to arrive 10-15 minutes early for your scheduled appointments***. As delays in the daily treatment schedule can adversely impact treatment for other patients, excessively late arrival for an appointment may require rescheduling at the practice's discretion. Though, we do understand that unforeseen issues can arise on occasion and you may need to cancel or reschedule your appointment, please be mindful that missed appointments prevent other patients with dental needs from being seen. Thus, we respectfully request ***at minimum 24 hours advance notice*** if you are unable to arrive for your scheduled appointment time. ***In instances of habitual tardiness, short-term cancellation, or failure to show for scheduled appointments, the practice may charge (at its discretion) a penalty fee to your account.***

☐ I authorize T. LANCE COLLIER, DMD, LLC to send my appointment reminders electronically via Email to the email address above and Text Message***** to the mobile number above.

MY MOBILE CARRIER: ☐ T-Mobile ☐ Sprint ☐ Verizon ☐ AT&T ☐ Other:_____

**This service is offered free of charge, however, standard text messaging rates from your mobile carrier may apply.*

SECURE ONLINE ACCOUNT ACCESS VIA OUR WEBSITE

Our office provides convenient and secure online access to your patient account via the "My Account" link on our website, **www.DrLanceCollier.com**. This service is free of charge and allows you to view upcoming scheduled appointments for you and your family, treatment history, treatment plans and current balance at any time. You can also access your statements and make payments on your account. Once enrolled, you will receive a password from our office via email, and can begin accessing your account immediately.

FINANCIAL POLICY STATEMENT:

Payment is due at the time services are rendered. Our office is an in-network provider for a select group of insurance carriers. As a courtesy to you, we may communicate with your insurance carrier to gather information on your eligibility and limits of benefits, and we may file claims on your behalf for treatment provided in this office. In this regard, we accept most traditional insurance policies. Patients with dental insurance are expected to pay their estimated deductibles and co-insurance at the time of treatment. Following claim payment, any remaining balance is your responsibility. Please be advised, though our office will make every effort to communicate to you accurate information with regards to your dental benefits, we are not and cannot be responsible for any inaccuracy of information conveyed from an insurance carrier. You are the policy holder, therefore an insurance carrier's obligation is to you and not to our office. Irrespective of any dental insurance benefits that might exist, you are always responsible for the entire cost of dental treatment. Those patients whose insurance carrier engages exclusively in direct reimbursement are required to pay for services in full at time of treatment; at our discretion, our office may file a claim on your behalf. We will be happy to discuss any special needs in the handling of your account. We accept cash, checks and credit cards.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

X Signature of Patient or Guardian_____ Date_____

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INITIAL CONSULTATION FORM

To help us get to know you, and to assist in learning your dental concerns, please provide us the following information.

NAME:_____ DATE:_____

In your own words, what is your main concern regarding your visit today?_____

_____

How long have you lived in this area?_____ Approximate Date of your Last Dental Visit: _____

Previous Dentist:_____ Previous Dentist's Phone #_____

Is there anything you would like to express about your dental health or past dental treatment?_____

_____

Are you in dental discomfort/**pain** today?	□YES	□NO	Do you or have you suffered from **Acid Reflux**?	□YES	□NO
Are your teeth sensitive to **cold** or **sweets**?	□YES	□NO	Do you or have you been told you **snore**?	□YES	□NO
Are your teeth sensitive to **hot** or **biting/chewing pressure**?	□YES	□NO	Have you been diagnosed with **Sleep Apnea** or do you wear a **CPAP** at night to sleep?	□YES	□NO
Do you **clench** or **grind** your teeth?	□YES	□NO	Have you noticed that any of your teeth may look **worn**?	□YES	□NO
Do you have frequent "tension" **headaches**?	□YES	□NO	Have you ever been treated for **TMJ** or **TMD**?	□YES	□NO
Are you **missing** any teeth?	□YES	□NO	Does your jaw ever **pop**, **click** or **lock**?	□YES	□NO
Are any of your teeth **loose**?	□YES	□NO	Do you currently wear any type of **dental appliance**(**orthodontic retainer** or **TMJ splint**)?	□YES	□NO
Do your **gums bleed** when you floss or brush?	□YES	□NO	Have you ever **broken** a tooth?	□YES	□NO
Have you ever been treated for **gum disease**?	□YES	□NO	Do you have any history of an **eating disorder**?	□YES	□NO
Are you concerned with having **bad breath**?	□YES	□NO	Do you feel that you suffer from "**dry mouth**?"	□YES	□NO
Have you had **orthodontic** treatment?	□YES	□NO	Do you have **anxiety** about dental work?	□YES	□NO

Are *you* satisfied with your smile? □YES □NO *WHY?*_____

Do you *like* your smile? □YES □NO _____

Do you *love* your smile? □YES □NO _____

Are there any specific dental treatments that you are interested in learning more about?

_____

_____

WHAT IS THE MOST IMPORTANT THING TO YOU IN CHOOSING A DENTIST OFFICE FOR YOU AND YOUR FAMILY'S NEEDS?

_____

_____