

**Choice Dental Centre of Greenwood**

**Michelle Lumsdon, D.D.S.**

**PATIENT REGISTRATION AND CONSENT**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status: M / S/ D/ W E-Mail address: \_\_\_\_\_

Person responsible for the account \_\_\_\_\_

Dental Insurance Yes No Secondary Insurance Yes No

Name of insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Employer \_\_\_\_\_ Insurance company \_\_\_\_\_

Social Security # \_\_\_\_\_ Or ID # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone number of the insurance company \_\_\_\_\_ Group Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Emergency

Number ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Consent for treatment:

The undersigned hereby authorizes Dr. Lumsdon or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I further authorize Dr. Lumsdon or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I understand that the use of any anesthetic agents involves certain risks. I understand the responsibility for the payment of dental services provided in this office for my dependents or myself is mine, due and payable at the time of services rendered. Insurance will be filed as a courtesy. Estimations are based on information from your insurance company. They are not a guarantee of payment. Regardless of financial arrangements the full responsibility of payment is mine. I further understand that any finance charges, refilling fees, collection charges, or attorney fees may be added to any overdue balance. I also assign all insurance benefits to Dr. Lumsdon. Please note that our HIPPA policy is available for your review upon request. A copy of the policy is also displayed in our reception area.

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ***Choice Dental Centre of Greenwood***

We are excited to welcome you and your family to our dental practice. At any time feel free to ask questions. Our office is open Monday, Tuesday, Thursday, and Friday. In case of a dental emergency, our phones are answered 24 hours a day. Should our voice mail system answer your call, please call the emergency number and Dr. Lumsdon will be notified. It is important to leave a call back number so your call may be returned.

At Choice Dental Centre of Greenwood we want your experience to be a good one. Let us know if you have any special concerns about your dental treatment. It is no surprise to us that the dental office is not everyone's favorite place to visit. Our goal is to change that opinion.

We will be happy to file insurance for you. Any estimation given is not a guarantee of payment and is based on information supplied by your insurance company. We strive to be as accurate as possible, however your insurance benefits are your responsibility and the total fee is your balance. We also understand that sometimes offering payment options can be helpful. We have several plans that allow you payment choices. Just ask if this would be helpful.

We offer a wide range of dental services. Cleanings, non-surgical gum treatment, white bonded fillings, crowns, bridges, cosmetic veneers, root canals, implant retained restorations, dentures, partials, and whitening to name a few. We offer such a wide range of services to our patients because we understand it takes time to become comfortable with a dental office. Therefore, unless it is in your best interest to be referred to a specialist, we want you to be treated here.

Finally, we always try to give a courtesy confirmation call the day before your appointment. We would appreciate if there becomes as need to cancel your appointment that you give us a 24 hour notice. We hold that time especially for you. We would hate to charge you for this time missed with the Doctor.

### ***We Want to Take Care of Your Concerns and Needs First...***

*How did you hear about us?* \_\_\_\_\_

*Why did you leave your last dentist?* \_\_\_\_\_

*What are your present dental problems?* \_\_\_\_\_

*Do you avoid brushing any part of your mouth?*  yes  no

*Do your gums bleed when brushing?*  yes  no

*Are your teeth sensitive to sweets, hot/cold, or biting pressure?*  yes  no

*Please rate how you feel about the appearance of your smile: Circle your answer*

*I like it very much I like it It's okay I would like to change it*

*What would you like to change about your smile?* \_\_\_\_\_

*What do you want to accomplish for today's visit?* \_\_\_\_\_

*Circle any of the following that you are interested in learning about.*

*Whitening Straightening w/o braces Tooth colored fillings Implants*

*Custom characterized dentures/partial Other* \_\_\_\_\_