Digital Dentistry
TM DISORDERS • IMPLANTS • FAMILY DENTISTRY

Robert C. Supple, D.M.D. - Tom D. Baiamonte, D.M.D., M.S. - Bethany Hann, D.D.S.

Patient Registration

First name _____ MI_____ Last _____

Address _____

City _____ State _____ Zip _____

Date of birth_____ Social Security # _____

Home phone _____ Cell_____ Work_____

Email_____ Driver's License # _____

Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Retired ☐

Please indicate your preferred way(s) of being contacted: Phone? ☐ Text message ? ☐ E-mail ? ☐

Insurance Information

Who will be responsible for payment?
Self ☐ Spouse ☐ Father ☐ Mother ☐ Insurance☐ Other ☐

Primary insurance

Insured's name _____

Date of birth _____

Insurance company _____

Group _____

Policy #_____

Employer _____

Social Security # _____

Secondary insurance

Insured's name _____

Date of birth _____

Insurance company _____

Group _____

Policy # _____

Employer _____

Social Security # _____

Insurance agreement

I certify that the above insurance information is correct and in force. 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 independent of insurance reimbursement.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Robert C. Supple, D.M.D. of the benefits otherwise payable to me. I agree to be responsible for any debt incurred by services rendered by Dr. Supple/Dr. Baiamonte if insurance does not pay. I agree to be responsible for any collections and/or attorney fees that might be due should I fail to pay any amount due to Dr. Supple/Dr. Baiamonte in full.

_____ _____

Signature of responsible party Date

Consent for treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. 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. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____	_____	_____
Signature of patient or authorized responsible party	Relationship	Date

We take pride in the fact that we are a caring and successful dental practice. Many people within the community have come to trust our care for all their dental needs. As a result, we have experienced a great deal of growth, which some of you have felt due to our schedule being booked three months or more in advance. Unfortunately, we are still experiencing lost time due to missed appointments. When time is lost due to appointment cancellations or no-shows, other patients in need of treatment cannot be seen and their treatment is delayed. For these reasons, we have had a 48-hour cancellation policy. However, we will be charging a $75 cancellation fee. Our policy is as follows:

Appointment cancellation policy

- We will make every effort to remind patients by telephone, text message, or email prior to the appointment, but please do not depend on this courtesy.
- Please remember that your appointment times are your responsibility.
- We strongly encourage all patients to keep their appointments. However, we also want your appointments to work for your schedule. If you need to change your appointment, we require a 48-hour notice with at least 24 hours notice to avoid a $75 cancellation fee.
- If commitments for appointments are frequently broken within the 48-hour period, a non-refundable reservation fee equal to the appointment fee may be required.

Our ultimate goal is to better serve all of our patients. Missed appointments are missed opportunities to better serve our patient base.

Cordially,

Robert C. Supple, D.M.D.
Tom D. Baiamonte, D.M.D., M.S.
Bethany Hann, D.D.S.

I have read and initialed the appointment cancellation policy (_____)

Health History Update

Please fill out the following questions to the best of your knowledge. Although dentists and hygienists primarily treat the mouth area, medical problems or medication could have a significant impact on your dental treatment. Your answers are for our records only and are confidential.

Name: _____ **Height:** _____ **Weight:** _____

(PLEASE WRITE IN BLOCK LETTERS)

Date: _____

1. Were there any changes in your general health in the past year? Y☐ N☐

If so, what were they? _____

_____

_____

2. Did you have a physical exam last year? Y☐ N☐
3. Were there any serious illness, accident, or surgery in the past 5 years? Y☐ N☐

If so, please describe _____

_____

_____

4. Have you received any chemotherapy or radiation for a growth, tumor, or other condition? Y☐ N☐

If so, please explain _____

_____

_____

5. Did you, or do you have an infectious disease (Aids, Hep c, HIV, TB) Y☐ N☐

If so, please clarify _____

6. Do you have prosthetic joints? Y☐ N☐

If so, please describe _____

_____

_____

7. Has your physician recommended that you take antibiotics prior to dental treatment? Y☐ N☐

If so, which medication _____

Please check if you currently have, or have had a history of the following medical conditions and allergies and indicate which medications you are currently taking:

Medical conditions				Medications			Allergies
☐	**None**	☐	High blood pressure	☐	**No medication**	☐	**No allergy**
☐	Allergies (hay fever)	☐	HIV	☐	Anti-anxiety	☐	**Aspirin**
☐	**Anemia**	☐	Hives	☐	**Antibiotic**	☐	**Barbiturates***
☐	Anxiety	☐	Jaundice	☐	**Anticonvulsants***	☐	Codeine
☐	Arthritis	☐	**Immune deficiency**	☐	Antidepressants	☐	**Ibuprofen**
☐	Artificial joints*	☐	Kidney disease	☐	**Aspirin**	☐	**Latex**
☐	Asthma	☐	Liver disease	☐	**Asthma medication**	☐	Local anesthetics
☐	Blood disease*	☐	Low blood pressure	☐	Birth control*	☐	**Narcotics**
☐	**Bruising easily**	☐	**Lupus**	☐	**Bisphosphonates**	☐	**Other medication***
☐	Cancer	☐	**Migraine/headaches**	☐	**Blood pressure**	☐	**Other substance***
☐	Chest pains	☐	Mitral valve prolapse	☐	**Blood thinners**	☐	**Pain killers***
☐	**Colitis**	☐	Multiple sclerosis	☐	**Cortisone**	☐	Penicillin
☐	**COPD**	☐	Osteopenia	☐	**CPAP**	☐	**Rubber**
☐	**Dental implant(s)**	☐	Osteoporosis	☐	**Diet pills**	☐	Sedatives
☐	**Depression**	☐	Other*	☐	**Heart medicine**	☐	Sulfa
☐	Diabetes	☐	Pacemaker	☐	**Herbal medicine**		
☐	**Dialysis**	☐	Pregnancy/nursing	☐	**Homeopathic remedies**		
☐	**Emphysema**	☐	Rash	☐	**Insulin**		
☐	Epilepsy	☐	Rheumatic fever	☐	**Minerals**		
☐	Fainting	☐	**Seizures**	☐	Other medicine/food*		
☐	**GERD**	☐	**Shingles**	☐	**Pain medicine**		
☐	**Glaucoma/vision**	☐	Sinus problems	☐	**Statins**		
☐	Heart attack	☐	**Sleep apnea**	☐	**Steroids**		
☐	Heart disease	☐	Stroke	☐	**Thyroid medicine**		
☐	Heart murmur	☐	Thyroid disease*	☐	**Vitamins***		
☐	Hepatitis	☐	Tuberculosis	☐			

(over) →

8. If you have checked any medication, please list: _____
_____
_____
_____

9. If you have checked any allergy, please list: _____
_____
_____
_____

10. If you have checked **"other"** please describe: _____
_____
_____
_____

11. Please write the name of any other dental specialist you consult: _____
_____

12. Which pharmacy fills your prescriptions? _____Phone: _____

_____ _____

Signature **Date**

Address: _____

_____

_____

Phones:

Land line _____

Cell _____

E-mail address: _____

Please indicate your preferred ways of being contacted:

Phone ☐ Text message ☐ E-mail ☐

We appreciate your taking the time to update our information. Thank you!