AUSTIN SMILE CREATIONS
Tor Gotun DDS, Cand. Odont, MAGD, PLLC

Patient Registration

Date:__________________ Chart #__________________

Name:______________________________________**Spouse/Parent Name:**____________________________

Address:____City:______________State:______Zip:________

Home Phone:____________________Work _______________________Cell____________________________

SSN____________________________Driver's License______________________________State:_____________

Birthdate:__________________ **Age:**______ **Sex:** ☐ Male ☐ Female E-Mail:__________________________

Are you: ☐ A Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer/School:____ ☐ Full-Time Student
Emp/Sch Address:____Phone:______________________

What is the reason for your visit? ____

You ☐ may ☐ may not use photos taken of me for educational purposes.

Whom may we thank for referring you?

☐ In area, saw sign ☐ Yellow Pages ☐ Internet Search:_________________________________

☐ Another Patient:__________________________ ☐ Doctor/Dental Office:______________________________

Medical History

☐ Abnormal Blood Pressure
☐ AIDS/HIV Positive
☐ Anemia
☐ Heart Problems
Describe______________________
☐ Arthritis
☐ Asthma
☐ Cancer_______________________
☐ Circulatory Problems
☐ Diabetes

☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting Tendency
☐ Frequent Headaches
How often?____________
☐ Glaucoma
☐ Hepatitis
☐ Jaundice
☐ Jaw Pain
☐ Kidney/Bladder Problems

☐ Osteoporosis
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sinus Problems/Allergies
☐ Smoking/Addictions
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Reaction to Dental Anesthesia
☐ Venereal/STD Problems

Other (please describe):____
____
Physician Name:____Phone:__________________________
List All Medicines You Are Currently Taking:____
____

Allergies: ☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex
☐ Penicillin ☐ Local Anesthetic ☐ Sulfa ☐ Other_____________________

Women: Are you pregnant? ☐ No ☐ Yes Due Date:_____________________
Are you a nursing mother? ☐ No ☐ Yes Are you taking birth control pills? ☐ No ☐ Yes

Emergency Contact: Name:____
Relationship to Patient:__________________________________
Home Phone:__________________Work Phone:_______________

(over)

 2724 Bee Caves Rd. ▪ Austin, TX 78746 ▪ p. (512) 329-5555 ▪ f. (512) 329-9049 ▪ www.austinsmilecreations.com

Insurance Information (if other than patient) (If patient, please present insurance card)

Name of Insured: ______________________ Relationship to Patient: ______________

Address: ______________________ City: ____________ State: ____ Zip: ________

Phone: ____________ Birth Date: ____________ Insurance ID #: ______________

Insurance Co.:______________________ Insurance Co. Phone: ______________

Group #: ____________ Plan Name / Employer Name: ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Insured: ______________________ Relationship to Patient: ______________

Address: ______________________ City: ____________ State: ____ Zip: ________

Phone: ____________ Birth Date: ____________ Insurance ID #: ______________

Insurance Co.:______________________ Insurance Co. Phone: ______________

Group #: ____________ Plan Name / Employer Name: ______________________

Responsible Party (**if other than patient**, review terms and sign as "Responsible Party" at end of form)

Name: ______________________ Relationship to Patient: ______________

Address: ______________________ City: ____________ State: ____ Zip: ________

Home Phone: ____________ Work Phone: ____________ Mobile Phone: ______________

Driver's License #: ____________ Social Security #: ______________ Sex: ☐ Male ☐ Female

Employer: ______________________ Employer Address: ______________________

As a condition of your treatment by this office, financial arrangements must be made in advance.

I understand that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed. Further, I understand that a separate written and signed Payment Agreement is required to finance any outstanding balance due. I also understand that it is my responsibility to alert this office about any changes in my ability to pay. _______ (Initials)

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that *I am financially responsible for payment in full of all accounts on which I am indicated as the responsible party*. I accept that this office may help prepare my insurance forms and assist in making collections from my insurance carrier or payor of my dental benefits for a maximum of 90 days following treatment. _______

I understand that a returned check fee (determined by law, currently $25.00) will be charged to my account for any check returned to this office by my bank. _______

I understand that a finance charge of 1.34% per month (16% per annum) will be imposed on any portion of the balance due on my account that exceeds 90 days, unless alternative written Payment Agreements are satisfied. _______

I understand that a late payment fee of $20.00 will be added to the balance due of my account if a payment is not received by the due date printed on my billing statement if credit is extended. Further, I understand that if I default on payment, I will also be charged service charges that will be greater than or equal to any court costs, attorney's fees, collection agency fees, and/or any other costs associated with collecting any incurred debt, as governed by the laws of the State of Texas. _______

I understand that an appointment is a reserved time slot on the schedule. I accept that if I cancel or reschedule an appointment with less than 24 hours notice, I may be charged a $25 fee. Further, I accept that if I cancel or reschedule an appointment that is longer than one (1) hour with less than 48 hours notice, I may be charged a minimum of 10% of estimated fees for the cancelled/rescheduled appointment not to exceed $100 per hour. _______

I authorize assignment of my insurance rights and benefits directly to Dr. Tor Gotun, DDS., PLLC for services rendered. _____

I grant permission to you, or your assignee, to telephone me at home or at work to discuss matters related to this form. ______

I have read the conditions of treatment and payment and agree to their content.

Signature of Responsible Party/Guarantor: ______________________ **Date:** ____________

Please do not sign this form in advance. Please sign it when you bring it filled out to our office at the time of appointment.