

CANYON GLOW DENTAL

701 N Highland Springs Ave, Suite 11 | Beaumont, CA 92223

PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name: _____	Preferred Name: _____
Date of Birth: _____	Pronouns (optional): _____
Home Address: _____	City/State/ZIP: _____
Mobile Phone: _____	Email: _____
Employer/School: _____	Occupation: _____
Social Security Number (optional): _____	

☐ Male ☐ Female ☐ Other / prefer to self-describe: _____ ☐ Prefer not to answer

RESPONSIBLE PARTY / PARENT / GUARDIAN

Name: _____	Relationship to Patient: _____
Date of Birth: _____	Phone: _____
Address (if different): _____ _____	

EMERGENCY CONTACT

Name: _____	Relationship: _____
Phone: _____	Alternate Phone: _____

HOW MAY WE CONTACT YOU?

☐ Call ☐ Voicemail ☐ Text message ☐ Email

Please tell us if there are any privacy restrictions or preferred ways to reach you: _____

REFERRAL / HOW DID YOU HEAR ABOUT US?

☐ Friend/Family ☐ Google/Search ☐ Insurance ☐ Social Media ☐ Nearby/Signage ☐ Other: _____

ACKNOWLEDGMENT

I certify that the information I have provided is accurate to the best of my knowledge and I will notify Canyon Glow Dental of changes to my contact, insurance, or health information.

Patient/Guardian Signature

Date

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MEDICAL HISTORY

GENERAL HEALTH

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary Care Physician: _____	Phone: _____
Preferred Pharmacy: _____	Phone: _____

☐ Yes ☐ No

Are you currently under the care of a physician? If yes, reason: _____

☐ Yes ☐ No

Have you been hospitalized or had major surgery? If yes, please explain: _____

MEDICAL CONDITIONS - CHECK ANY THAT APPLY

☐ Heart disease / heart attack	☐ High blood pressure	☐ Heart murmur	☐ Pacemaker / implanted device
☐ Stroke / TIA	☐ Bleeding disorder	☐ Diabetes	☐ Thyroid disease
☐ Asthma / breathing problems	☐ Kidney disease	☐ Liver disease / hepatitis	☐ Seizures / epilepsy
☐ Cancer / chemotherapy / radiation	☐ Osteoporosis / bone medications	☐ Autoimmune condition	☐ Joint replacement
☐ Sleep apnea	☐ GERD / reflux	☐ Anxiety / depression	☐ Other: _____

ALLERGIES / REACTIONS

☐ No known drug allergies ☐ Penicillin / amoxicillin ☐ Latex ☐ Local anesthetic ☐ Other: _____

MEDICATIONS

List all prescription medications, over-the-counter medications, vitamins, supplements, injections, and blood thinners.

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

ADDITIONAL HEALTH INFORMATION

☐ Yes ☐ No

Do you take antibiotics before dental treatment? If yes, why? _____

☐ Yes ☐ No

Have you ever taken Fosamax, Actonel, Boniva, Reclast, or any other bisphosphonate medication? If yes, please list the medication and approximate dates: _____

☐ Yes ☐ No ☐ N/A

Are you pregnant, possibly pregnant, nursing, or undergoing fertility treatment? Details (optional): _____

☐ Yes ☐ No

Do you use tobacco, nicotine, vaping products, cannabis, or recreational drugs? If yes, please describe: _____

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DENTAL HISTORY

YOUR DENTAL EXPERIENCE

When was your last dental visit?

Reason for visit: _____

Please place a check mark in the box next to the statement that concerns you or describes your problem.

☐ Dental anxiety or fear	☐ Sensitivity to hot / cold / sweets	☐ Bleeding gums	☐ Bad breath or bad taste
☐ Loose teeth	☐ Grinding or clenching	☐ Jaw pain / clicking / locking	☐ Frequent headaches
☐ Difficulty chewing	☐ Dry mouth	☐ Mouth sores	☐ History of gum disease
☐ History of root canals	☐ History of braces / aligners	☐ Dental implants	☐ Dentures / partials
☐ Sleep apnea appliance	☐ Snoring	☐ Prior dental trauma	☐ Unhappy with smile appearance

COMFORT PREFERENCES

- ☐ Please explain each step ☐ I prefer minimal details ☐ Take breaks as needed ☐ Please use extra topical anesthetic
- ☐ I have a sensitive gag reflex - please be gentle ☐ My teeth are sensitive ☐ I feel anxious about injections / needles
- ☐ The sound of the dental drill makes me uncomfortable ☐ Please discuss costs before treatment ☐ Other:

CONSENT TO DISCUSS TREATMENT

I understand that this history helps my dental team plan safe, individualized care and that I should update Canyon Glow Dental if my dental or medical history changes.

Patient/Guardian Signature

Date

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DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Company: _____	Member / Subscriber ID: _____
Subscriber Name: _____	Subscriber DOB: _____
Patient Relationship to Subscriber: _____	Group / Plan No.: _____
Subscriber Employer: _____	Insurance Phone: _____

SECONDARY DENTAL INSURANCE

Insurance Company: _____	Member / Subscriber ID: _____
Subscriber Name: _____	Subscriber DOB: _____
Patient Relationship to Subscriber: _____	Group / Plan No.: _____

INSURANCE AUTHORIZATION

I authorize Canyon Glow Dental to obtain benefit information and submit claims to my dental benefit plan on my behalf. I understand that benefit information is an estimate and is not a guarantee of payment. I am responsible for charges not paid by my plan, subject to applicable contracts and law.

☐ Please send insurance payments directly to Canyon Glow Dental when permitted by my plan.

DOCUMENTS PROVIDED

☐ Insurance card / digital card ☐ Photo ID ☐ Other: _____

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FINANCIAL POLICY

OUR FINANCIAL GUIDELINES

Payment at time of service: Estimated patient portions, copayments, deductibles, and non-covered services are due at the time of service unless other arrangements have been approved.

Insurance estimates: As a courtesy, we can help verify benefits and submit claims. Dental plans vary, and quoted benefits are estimates rather than guarantees of payment.

Balances after insurance: Any remaining patient responsibility after insurance processes a claim is due upon receipt of the statement.

Changes in coverage: Please notify us promptly if your insurance, address, phone number, or responsible party changes.

Treatment estimates: We will provide treatment and fee estimates when appropriate. Actual benefits or treatment needs may change.

Missed appointments: Please provide as much notice as possible if you need to reschedule. Repeated late cancellations or missed appointments may affect future scheduling. Any fee policy should be disclosed to you before it is applied.

PAYMENT PREFERENCE

☐ Dental insurance ☐ Cash / self-pay ☐ Canyon Glow Dental Membership Plan ☐ CareCredit / third-party financing ☐ Credit / debit card ☐ HSA / FSA ☐ Other: _____

Please check all that apply. Insurance benefits and financing approval are not guaranteed; estimated patient portions remain the patient's responsibility.

ACKNOWLEDGMENT

I have read and understand the financial guidelines above. I understand that I may request clarification about charges, estimates, or insurance processing before treatment.

Patient/Responsible Party Signature

Date

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PRIVACY & COMMUNICATION PREFERENCES

NOTICE OF PRIVACY PRACTICES

Canyon Glow Dental maintains a Notice of Privacy Practices describing how health information may be used or disclosed and how patients may exercise privacy rights. By signing below, I acknowledge that I was offered access to or received the practice Notice of Privacy Practices.

☐ I received / was offered the Notice of Privacy Practices.

PEOPLE WE MAY SPEAK WITH

I authorize Canyon Glow Dental to discuss appointment, billing, insurance, and/or treatment information with the following person(s), subject to the limits I indicate:

Name: _____	Relationship: _____	☐ Appointments ☐ Billing ☐ Treatment
Name: _____	Relationship: _____	☐ Appointments ☐ Billing ☐ Treatment

COMMUNICATION PREFERENCES

☐ Phone call ☐ Voicemail ☐ Text message ☐ Email

Voicemail instructions or restrictions: _____

I understand that ordinary text messages and emails may have privacy risks depending on my device, service provider, and account settings. I may update these preferences by notifying the office.

PHOTO / CLINICAL IMAGE PREFERENCE

- ☐ I allow clinical photographs/x-rays to be used for my dental record and treatment planning.
- ☐ Please ask me separately before using any de-identified image for education, website, social media, or marketing.

ACKNOWLEDGMENT

Patient/Guardian Signature

Date

Practice note: This packet is a customizable office template and should be reviewed against your final HIPAA, financial, cancellation, texting/email, and insurance policies before implementation.