PATIENT REGISTRATION

CHART ID: _____________ DATE: ___________________

FIRST NAME: ________________________ LAST NAME: ________________________ MIDDLE INITIAL: _______

ADDRESS: ____

CITY: ______________________________ STATE: ________________ ZIP: ____________________

HOME PHONE: ______________________________ SEX: MALE FEMALE

CELL PHONE: ______________________________ DOB: ________________ AGE: ________

WORK PHONE: ______________________________ SSN: ______________________________

E-MAIL: __________________________________ DRIVERS LIC: ________________________

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPERATED WIDOWED

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED PREFERED DENTIST: ________________________

STUDENT STATUS: FULLTIME PART TIME PREFERED PHARMACY: ________________________

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

FIRST NAME: ________________________ LAST NAME: ________________________ MIDDLE INITIAL: _______

ADDRESS: ____

CITY: ______________________________ STATE: ________________ ZIP: ____________________

HOME PHONE: ______________________________ PRIMARY INSURANCE HOLDER: YES NO

CELL PHONE: ______________________________ DOB: ________________ AGE: ________

WORK PHONE: ______________________________ SSN: ______________________________

E-MAIL: __________________________________ DRIVERS LIC: ________________________

INSURANCE INFORMATION

PRIMARY:

NAME OF INSURED: ____________________________

RELATIONSHIP: ____________ DOB: ______________

INSURED SSN: ______________________________

INSURANCE: ________________________________

POLICY NUMBER: ____________________________

ADDRESS: __________________________________

CITY: ______________ STATE: _______ ZIP: ________

SECONDARY:

NAME OF INSURED: ____________________________

RELATIONSHIP: ____________ DOB: ______________

INSURED SSN: ______________________________

INSURANCE: ________________________________

POLICY NUMBER: ____________________________

ADDRESSS: _________________________________

CITY: ______________ STATE: _______ ZIP: ________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you make be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions so that we may treat you to the best of our ability. Thank you!

Are you under a physician's care now? ○Yes ○ No If yes, explain: ______________________________
Have you ever been hospitalized or had a major operation? ○Yes○No If yes, explain: ______________________________
Have you ever had a serious head or neck injury? ○Yes○ No If yes, explain: ______________________________
Are you taking any medications, pills or drugs? ○Yes○ No If yes, explain: ______________________________
Do you take, or have you taken, Phen-Fen or Redux? ○Yes○ No If yes, explain: ______________________________
Are you on a special diet? ○Yes○ No If yes, explain: ______________________________
Do you use tobacco? ○Yes○ No If yes, explain: ______________________________
Do you us controlled substances? ○Yes○ No If yes, explain: ______________________________

WOMEN ONLY:
Are you pregnant or trying to get pregnant?○ Yes○ No Taking oral contraceptives?○ Yes ○No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
○ASPRIN ○ PENICILLIN ○CODIENE ○ACRYLIC ○ METAL ○LATEX ○ LOCAL ANESTHETICS
○OTHER: ______________________________

Do you have, or have you had, any of the following? Check yes if any applies to you:

__ AIDS/HIV Positive
__ Alzheimer's Disease
__ Anaphylaxis
__ Anemia
__ Angina
__ Arthritis/Gout
__ Artificial Heart Valve
__ Artificial Joint
__ Asthma
__ Blood Disease
__ Blood Transfusion
__ Breathing Problem
__ Bruise Easily
__ Cancer
__ Chemotherapy
__ Chest Pains
__ Cold Sores/Fever Blisters
__ Congenital Heart Disorder
__ Convulsions
__ Cortisone Medicine
__ Diabetes
__ Drug Addiction
__ Easily Winded
__ Emphysema
__ Epilepsy or Seizures
__ Excessive Bleeding
__ Excessive Thirst
__ Fainting Spells/Dizziness
__ Frequent Cough
__ Frequent Diarrhea
__ Frequent Headaches
__ Genital Herpes
__ Glaucoma
__ Hay Fever
__ Heart Attack/Failure
__ Heart Murmur
__ Heart Pace Maker
__ Heart Trouble/Disease
__ Hemophilia
__ Hepatitis A
__ Hepatitis B or C
__ Herpes
__ High Blood Pressure
__ Hives or Rash
__ Hypoglycemia
__ Irregular Heartbeat
__ Kidney Problems
__ Leukemia
__ Liver Disease
__ Low Blood Pressure
__ Lung Disease
__ Mitral Valve Prolepses
__ Pain in Jaw Joints
__ Parathyroid Disease
__ Psychiatric Care
__ Radiation Treatments
__ Recent Weight Loss
__ Renal Dialysis
__ Rheumatic Fever
__ Rheumatism
__ Scarlet Fever
__ Shingles
__ Sickle Cell Disease
__ Sinus Trouble
__ Spina Bifida
__ StomachIntestinalDisease
__ Stroke
__ Swelling of Limbs
__ Thyroid Disease
__ Tonsillitis
__ Tumors or Growths
__ Ulcers
__ Venereal Disease
__ Yellow Jaundice
__ OTHER: ____________
____

COMMENTS: ______________________________
____
____

To the best of my knowledge, the questions on this form have been correctly answered. I understand that providing incorrect information can be dangerous to my (or the patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature: ______________________________ Date: ____________________

QUESTIONNAIRE

Patient Name: ____ Date: __________________________

Please take the time to answer the following questions for us. This will help us to better understand and address each of your unique concerns.

1. Were you referred to our office? YES NO
2. If so, who may we thank for your referral? ____
3. When was your last professional cleaning and by whom? ____
   a. Where there X-Rays taken at that time? YES NO
4. How often do you have your teeth cleaned? ____
5. How often do you floss your teeth? ____
6. Do you have sensitive teeth? YES NO
7. Do you have a history of gum disease? YES NO
   a. If so, have you seen a specialist? YES NO
8. How do you feel about dental visits? RELAXED ANXIOUS NEUTURAL
9. Tell us about your habits. Do you….?
   a. Grind or Clench? YES NO
   b. Bite your fingernails? YES NO
   c. Smoke? YES NO If yes, how many per day? __________________________
   d. Use smokeless tobacco? YES NO
   e. Use a hard toothbrush? YES NO
10. Do you or your partner snore? YOU YOUR PARTNER BOTH
11. Do you feel tired during the day? YES NO
12. Does your bite feel right? YES NO
    a. If no, please explain.

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       ____
13. Do you wake up with headaches? YES NO
14. Do your jaw joints hurt? YES NO
15. Have you had Orthodontics (braces)? YES NO
    a. If so, who did them and when were they removed? ____
16. Do you like the appearance of your teeth? YES NO
17. What about the appearance of your teeth bothers you?
    a. Stains ___
    b. Color ___
    c. Spaces ___
    d. Chips or cracks ___
    e. Length ___
    f. Crooked teeth __
    g. Unattractive: Crowns or Bonding
    h. White or dark spots ___
    i. Shape of teeth ___
18. Would you like your smile to look 10 years younger? YES NO
19. Are you concerned about a receding gumline? YES NO
20. Do you want to have any missing teeth replaced? YES NO
21. Do you have any silver fillings that you would like to have replaced with new white bonded fillings? YES NO
22. Do you have teeth that you believe need porcelain veneers or all-porcelain crowns? YES NO
23. Would you like to learn more about invisible braces? YES NO

Please tell us more about your dental goals: ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: ________________________

I, ____, have received a copy of Dothan Cosmetic Dentistry NOTICE OF PRIVACY PRACTICES. I acknowledge that I understand the use of my private information for treatment and insurance purposes. I give my consent for Dothan Cosmetic Dentistry to file my information for me.

Patient Signature: ____

Witness Signature: ____

STATEMENT OF FINANCIAL RESPONSIBILITY

Assignment of Insurance Benefits

I hereby authorize payment directly to Dothan Cosmetic Dentistry of all medical benefits otherwise payable to me or on my behalf for the treatment(s) performed and/or service(s) rendered at Dothan Cosmetic Dentistry. I understand any payment sent directly to me shall then be forwarded to Dothan Cosmetic Dentistry. I understand any unpaid deductibles, co-pays, or co-insurance amounts not payable by my insurance are my responsibility regardless of any pending insurance amounts. These amounts due from me are due on the date of service. This assignment of benefits is valid for insurance companies and programs.

Authorization of Release of Information

I authorize Dothan Cosmetic Dentistry to release any and all medical information concerning the treatment(s) and/or service(s) performed at Dothan Cosmetic Dentistry as may be required by my insurance company in order to process payment of my claim(s).

Charges

I understand that standard charges have been established for all services at Dothan Cosmetic Dentistry. I further understand that the fee(s) for my treatment(s) and/or service(s) performed at Dothan Cosmetic Dentistry will be billed to my insurance company. If any additional treatment(s) and/or service(s) are deemed necessary by my physician, and performed today, those treatment(s) and/or service(s) will be billed to my insurance company as well.

Credit Policy

Dothan Cosmetic Dentistry will file the appropriate claim forms to my insurance carrier. I will be notified when the final action (payment, denial, etc.) by my insurance carrier has been received. I understand that if my account becomes delinquent it will be placed with Prim and Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & ½ percent per month (18% per annum); (2) I agree and hereby consent that I will be responsible for reasonable collection costs, attorney's fees, and any court costs that are incurred by Dothan Cosmetic Dentistry in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction. I agree that if I have listed a cell phone number as a point of contact that I can be called at that number regarding my balance. Additionally, I agree to waive any and all state and/or federal personal property exemptions, wage exemptions, and/or homestead exemptions of my state of residence and/or state of operation in the event of judgment, levy, and/or garnishment. Further, if I reside in Florida or Georgia I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance.

I, ____, have read and understand the terms of this policy statement.

____ ______________

Patient's Signature (Parent or Guardian if Minor) Date

____ ______________

Signature of Insured if other than Patient Date