

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: _____

ADDRESS: _____

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:

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

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. Where 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 NEUTRAL
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.

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 ____	d. Chips or cracks ____	g. Unattractive: Crowns or Bonding
b. Color ____	e. Length ____	h. White or dark spots ____
c. Spaces ____	f. Crooked teeth ____	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: _____

**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 & 1/2 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