Patient Registration

Patient Information: Date:_______________________

Name_____________________________________Name you go by_________________Birthdate____________Age____

Address____City_________________________State______Zip_________

Home phone #___________________Cell Phone #________________________Work Phone #____________________

E-mail Address____

Employer________________________________Soc.Sec.#______________________Driver's License #______________

Sex____Marital Status: S__M__W__D__ Spouse's Name________________________Spouse's Birthdate______________

Spouse's Employer_________________________________Spouse's Soc. Sec. #___________________________________

Other family members in this practice____

Whom may we thank for referring you?____

Responsible Party Information:(If different than patient)

Name of Responsible Party____________________________Relationship to patient___________Birthdate________

Address_______________________________________City________________________State_______Zip_________

Home phone #_______________Work phone#____________________Soc. Sec.#____________________________

Primary Insurance:

Name of Subscriber____Birthdate__________________________

Employer____Group/Policy #______________________

Name of Insurance Company____

Soc. Sec.#____________________Contract/Insurance I.D.#____

Address to send claims to____

Secondary Insurance:

Name of Subscriber____Birthdate__________________________

Employer____Group/Policy #______________________

Name of Insurance Company____

Soc. Sec.#____________________Contract/Insurance I.D.#____

Address to send claims to____

(OVER)

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure (s) involved will be given by the doctor and/or his staff. I accept the fee charged as a lawful debt and promise to pay said fee including the collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. For those patients with insurance, I authorize release of any information to all my insurance companies. I authorize payment directly to this office insurance benefits otherwise payable to me or my dependents, and I understand that all charges will be due and payable by the responsible party, no later than 60 days after the date of service, if the insurance has not paid.

Patient's or Guardian's signature____Date____________________

By signing below, I acknowledge that I have reviewed a copy of Notice of Privacy Practices and I consent to the dentist's use and disclosure of my records(or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment of payment.

Patient's or Guardian's signature____Date____________________

Consent to Receive Text Messages or Emails about Appointment Reminders: Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

____ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders is ____________________.

The email that I authorize to receive email messages for appointment reminders is ____________________________.

The practice does not charge for the this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

<u>Revocation</u>

I hereby revoke my request for future communications via email and/or text.

____I hereby revoke my request to receive any future appointment reminders via text messages.

____I hereby revoke my request to receive any future appointment reminders via email.

Medical History

Physician's Name____ Date of Last Physical____________

Are you allergic to any of the following? (Please check if Yes)

Aspirin	___	E-mycin	___
Barbiturates	___	Penicillin	___
Codeine	___	Sulfa	___
Latex	___	Tetracycline	___
Dental Anesthetics	___	Other Antibiotics:	________________________________
Jewelry/Metals	___	Other Drugs:	________________________________

Have you had any joint replacements? Y___N___ Do you require antibiotics before dental work? ___Yes___No
Circle any blood thinners you are currently taking: Aspirin, Aggrenox, Coumadin, Heparin, Lovenox, Plavix, Warfarin

<u>Please check any of the following conditions you have had or have at present.</u>

AIDS-HIV	___	Anemia	___	Angina	___
Arthritis	___	Asthma	___	Artificial Heart Valve	___
Cancer	___	Canker Sores	___	Chest Pains	___
Diabetes	___	Emphysema	___	Circulatory Problems	___
Epilepsy	___	Hepatitis	___	Bleeding/clotting problems	___
Fainting	___	Heart Murmur	___	Heart Attack	___
High Blood Pressure	___	Ulcer	___	Thyroid Problem	___
Headaches	___	Kidney Disease	___	Leukemia	___
Liver Disease	___	Mental Disorder	___	Mitral Valve Prolapse	___
Chronic Sinus	___	Stroke	___	Tuberculosis	___

Please list other health complications not listed above: ____
____

Please list all medications you are currently taking. ____
____

Women (Please check): ___Pregnant ___Trying to get pregnant ___Nursing ___Taking Birth Control

Dental History

Approximate date of last dental exam____________________		Are you in pain?	___Yes ___No
Have you ever had any gum treatment or surgery?	___Yes ___No	Do your gums ever bleed?	___Yes ___No
Do you have mobility in your teeth?	___Yes ___No	Do you use tobacco?	___Yes ___No
Do you have popping or clicking in your jaw?	___Yes ___No	Do you brush daily?	___Yes ___No
Do you grind or clinch your teeth?	___Yes ___No	Do you floss daily?	___Yes ___No
Are your teeth sensitive to heat or cold?	___Yes ___No	Would you like fresher breath?	___Yes ___No
Do you snore or use a CPAP macine?	___Yes ___No	Would you like whiter teeth?	___Yes ___No
Are you happy with the way your smile looks?	___Yes ___No		

If not, what would you change?____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

Signature of patient, parent, guardian____ Date____________