

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				<b>1</b>
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		<b>2</b>
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

<b>GETTING TO KNOW YOU</b>		<b>3</b>
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
<b>YOU WERE REFERRED TO US BY</b>		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name \_\_\_\_\_

# DENTAL HISTORY

Patient Account No. \_\_\_\_\_

Medical Alert \_\_\_\_\_

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_

(Please complete other side)

# MEDICAL HISTORY

Patient Name \_\_\_\_\_

Patient Account No. \_\_\_\_\_

Medical Alert \_\_\_\_\_

1. Have you been under the care of a medical doctor during the past two years?..... Yes No  
If yes, for what? \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... Yes No  
If yes, please list name and dosage \_\_\_\_\_
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phenentermine); Pondimin (fenfluramine); and Redux (dexendfluramine)?..... Yes No  
If yes to the above, did you have a medical exam for heart issues?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No  
If yes, please list: \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)....	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Blood Transfusion.....	Yes	No
Artificial Heart Valve.....	Yes	No	Chronic Cough.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever.....	Yes	No	Liver Disease.....	Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice.....	Yes	No
Swollen Ankles.....	Yes	No	Allergies or Hives.....	Yes	No	Neurological Disorders.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Artificial Joints (hip, knee, etc.)....	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No
8. Do you use more than two pillows to sleep?..... Yes No
9. Have you lost or gained more than 10 pounds in the past year?..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed?..... Yes No  
If yes, please list: \_\_\_\_\_
11. Women: Are you pregnant or think you may be pregnant? Yes, \_\_\_\_\_ Months No Nursing? Yes No
12. Women: Do you use birth control medications?..... Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Smile Center of Fayette  
Terry McCulloch D.D.S.**

**Practice /Patient Agreement**

**The following policy must be read and signed by the patient or insurance holder prior to being seen in this office.**

1. Patients should understand that he/she is **responsible for payments of all fees on their account.** Payment is required at the time of service. We accept cash, check, Visa, Master Card, or Debit cards. If payments have insurance, the insurance card must be presented at check-in so that the coverage can be verified. (Initials \_\_\_\_\_)
2. As a courtesy, we will file the patients primary insurance. Filing insurance is **NOT** a means of payment and does not excuse the patient from paying the co-payment or co-insurance today. It is imperative for the patient to understand that there could be a remaining balance to be paid by the patient after the insurance company has paid its balance. The balance after 45 days is the **responsibility of the patient** and is subject to a late fee of, \$25.00 per month. (Initials \_\_\_\_\_)
3. **The patient must understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid for them, since we do NOT have complete access to insurance records. The patient is responsible for knowing their insurance coverage. To avoid misunderstandings, insurance specialists are available to answer questions before the patients visit.** (Initials \_\_\_\_\_)
4. We do not accept responsibility for negotiating claims with the patients insurance company or any other persons. Reduction or rejection of the patients claim by their insurance company does not relieve the financial obligation they have incurred. (Initials \_\_\_\_\_)
5. If the patients prefers to file for insurance, fees are payable at the time services are rendered.  
**\*\*\*We require 24 hours notice for cancellation of a scheduled appointment (Notice must be give by 8:00 am on the Friday prior to Monday appointments). Failure to give proper notice will result in a \$50.00 fee which must be paid before your appointment. (Initials \_\_\_\_\_)**

Please take the time to read and sign our office policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

