PATIENT REGISTRATION

First Name:_____ Middle Name:_____ Last Name:_____

Sex: **Male** **Female** DOB:_____ Marital Status: **Single** **Married** **Divorced** **Separated** **Widowed**

SS# (required):_____-_____-_____ Driver's License #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

E-Mail:_____

Contact Preference: ☐ **E-Mail** ☐ **Cell** ☐ **Work** ☐ **Home** ☐ **Text** **Best Contact Time:** ☐ **AM** ☐ **PM**

Occupation:_____ Employer:_____

IN CASE OF EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone #: _____-_____-_____

PRIMARY DENTAL INSURANCE: (If any SECONDARY INSURANCE, it must be filed by the patient)

Policy Holder:_____ DOB: _____ SS#:_____-_____-_____

ID#:_____ Group #:_____ Employer:_____

Insurance Company_____ Insurance Phone #: _____-_____-_____

DENTAL HISTORY

Previous Dentist:_____ Phone #:_____-_____-_____ Last Dental Visit:_____ New Patient: **Y or N**

How often do you Floss:_____ Brush:_____ Do you want whiter teeth? _____

Are you happy with your smile? If no, explain _____

Reason for today's visit: _____

PLEASE CHECK ANY THAT APPLY:

☐ Are you apprehensive about dental treatment	☐ Wear Dentures	☐ Sensitivity to hot or cold	☐ Stained teeth
☐ Discomfort, Clicking, Locking or Popping in jaw	☐ Lost or Broken Fillings	☐ Sensitivity to sweets	☐ Speech problems
☐ Blisters/Cold Sores in or around the mouth	☐ Habitual Gum Chewer	☐ Gag Easily	☐ Ringing ears
☐ Finger/Thumb Sucking	☐ Loose teeth or change in bite	☐ Trap food between teeth	☐ Tobacco Habit
☐ Red, swollen or bleeding gums	☐ Pain (in joint, ear, side of face)	☐ Teeth grinding/clenching	☐ Headaches

Other:_____

HOW DID YOU HEAR ABOUT US?

☐ Office Website ☐ Internet ☐ Facebook ☐ Drive By ☐ Referral If referral, who? _____

NO SHOW AND CANCELLATION FEES

When we make your appointment, we prepare your records and reserve time for your particular needs. We ask that if you must change an appointment, please give us at least 48 BUSINESS hours notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We reserve the right to reschedule your appointment time if you are more than 15 minutes late. It is your responsibility to notify us of any change in your contact information.

There is a $50 charge for not showing up to your scheduled appointment and for any cancellations made less than 48 BUSINESS hours prior to your appointment.

Repeated cancellations, reschedule, or missed appointments will result in loss of future appointment privileges.

MEDICAL HISTORY

Physician's Name _____

Phone: _____ - _____ - _____ Date of last visit: _____

Are you currently under physician care? **Y N**

If yes, describe _____

Have you ever had any serious illnesses or operations? **Y N**

If yes, describe _____

Have you ever had a blood transfusion? **Y N**

If yes, give approximate date _____

WOMEN ONLY:

Pregnant? **Y N** Nursing? **Y N** Taking birth control or other hormones? **Y N**

Medications:

Are you taking blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko, Biloba, Aggrenox, Pradaxa, Fish Oil)? **Y N**

Are you taking, or have you ever taken, bone density meds, bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia in the past 12 years? **Y N**

List any other medications:_____

_____

_____

_____

ARE YOU ALLERGIC TO: (please circle)

Anesthetics Penicillin Sulfa drugs Aspirin Amoxicillin Narcotics Latex Erythromycin Tetracycline Acetaminophen Ibuprofen

Other: _____

CHECK ALL THAT APPLY:

___AIDS/HIV Positive	___Circulatory Problems	___History of drug abuse	___Rheumatic/Scarlet fever
___Anaphylaxis	___Diabetes	___Kidney Disease	___Shingles
___Anemia	___Epilepsy	___Liver Disease	___Shortness of breath
___Arthritis/Rheumatism	___Fainting	___Mitral valve prolapse	___Stroke
___Artificial Heart Valves	___Glaucoma	___Nervous problems	___Surgical implant
___Artificial joints/bones	___Heart Murmur	___Pacemaker/Heart Surgery	___Thyroid disease
___Asthma	___Hemophilia	___Psychiatric care	___Tobacco habit
___Atopic (allergy prone)	___Herpes	___Rapid weight gain/loss	___Tonsillitis
___Blood disease	___Hepatitis; Type ____	___Radiation treatment	___Tuberculosis
___Cancer	___High Blood Pressure	___Removable dental appliance	___Ulcer/Colitis
___Chemical Dependency	___History of alcohol abuse	___Respiratory disease	___Veneral disease

UPDATES

Initials	Date
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

PHARMACY INFORMATION:

Name:_____ Phone #:_____-_____-_____

Do you Require Pre-Medication: ☐ **Yes** ☐ **No** ☐ **Don't Know**

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

I **acknowledge** that I have received the "Notice of Privacy Practices" of James H. Donelson D.D.S., Inc. By signing this form, I consent to the use and disclosure of myself and my minor dependents protected health information to carry out treatment, payment activities, and healthcare operations.

Signature_____ **Date**_____/_____/_____