



Patient Registration Form (CONFIDENTIAL)

Section I: Patient Information Date _____

Name: _____ I Prefer to be called: _____
Address: _____ City: _____ State: _____ Zip _____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: Minor Single Married Widowed Separated Divorced
Spouse or Parent's Name: _____ Employer _____ Work Phone _____
Person to contact in case of emergency _____ Phone _____
Please circle one of the following for confirmation e-mail, text, or phone call.
Email Address _____ .

Section II Responsible Party

Relationship to Patient: Self Spouse Parent Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (_____) _____
Employer _____ Work Phone (_____) _____ SSN# _____

Section III Insurance Information

Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Company _____ Grp # _____ ID# _____
Ins Co Address: _____ Ins Co. Phone: _____

----- DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING -----

Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Company _____ Grp # _____ ID# _____
Ins Co Address: _____ Ins Co. Phone: _____



Section IV

Patient Medical History

Name _____

Physician _____

Office Phone _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1 Are under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Are you taking any medication(s), including Non-prescription medication?.....
If yes, what medication(s) are you taking.....
.....
..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Have you ever taken Phen-Fen/Redux | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Do you use tobacco?.....
Please circle : Smoke or chew | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Are you wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Do you have or have you had any of the following? | | |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 9 Are you allergic or have you had any reaction to the following? | | |
| Local Anesthetics (eg. Novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pencillin or any other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals(e.g. nickel, mercury, etc)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Women Only | | |
| a.) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b.) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c.) Are taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Do you want or need nitrous oxide..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|------------------------------|--------------------------|--------------------------|
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles/Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|
| Heart Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker.... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement or Implant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|----------------------------|--------------------------|--------------------------|
| Chest Pain..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever/Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ **Date of Last Exam** _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1 Do your gums bleed while brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Are your teeth sensitive hot or cold liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Are your teeth sensitive to sweet or sour liquids/foods?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Do you have sores or lumps in or near your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Continue on Back of Page



Patient Dental History- continue

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 7 Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 13 Have you received oral hygiene instructions regarding the care of your teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Do you bite your lips or cheeks frequently?..... | <input type="checkbox"/> | <input type="checkbox"/> | 14 Have you ever experienced any of the following problems with your jaw? | | |
| 9 Have you ever had any difficult extractions in the past?..... | <input type="checkbox"/> | <input type="checkbox"/> | - Clicking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Have you ever had any prolonged bleeding following extraction?..... | <input type="checkbox"/> | <input type="checkbox"/> | - Pain (joint, ear, side of face).... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Have you had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | - Difficulty in opening or closing... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 Do you wear dentures or partials.....
If yes, date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> | - Difficulty in chewing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15 Do you like your smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Financial Commitment:

Our office will gladly create and file your primary and secondary dental insurance claims for your convenience, we **do not** file medical insurance. We will estimate your benefits based on a "typical" dental insurance plan, or based on the information we have gathered about your specific dental plan. As a courtesy to our patients, we will accept assignment from your insurance company, but you will be expected to pay the difference between the full fee and the insurance **estimate** at the time services are rendered unless further financial arrangements are discussed in advance. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

I authorize and request my dental insurance company to pay directly to Dr. Jerald Bryant and Dr. Carol Baxter for services rendered on my behalf or my dependent. If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Dr. Jerald Bryant and Dr. Carol Baxter, or make payment directly to Dr. Jerald Bryant and Dr. Carol Baxter. A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though insurance may be pending.

I agree to be responsible for payment of all services rendered on my behalf and my dependent.

A fee of \$29.00 will be incurred for each returned check.

I agree to pay collection cost, attorney's fees, court costs, and interest from the date of treatment if this account is assigned to collection status.

I certify that I have read, understand and agree to the insurance acceptance outlined above. I authorize this office to discuss my account with a spouse or parent/step parent (if patient is not a minor but using parent or step parent insurance).

Signature – Person Financially Responsible for the Account

Date

Authorization and Release:

I certify that I have read, understand and agree to the above information to be best of knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such Dental care to the third party payors and/or health practitioners.

Signature of Patient (or parent/guardian if minor)

Date