Patient Registration

Current Date: ____/____/____

First Name _____ Last Name _____MI _____

Responsible Party (If someone other than the patient): Name _____

Patient Information: Street Address:

City _____State _____Zip:_____

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

Sex: Male☐ Female ☐ Married☐ Single☐ Divorced☐ Separated☐ Widowed ☐

Birth Date: _____ Social Security Number: _____

E-mail: _____ Employer_____

Student Status: Full Time☐ Part Time☐

Height_____ Weight:_____

Whom may we thank for your referral? _____

What can we help you with? _____

_____

Emergency Contact: Name _____ Phone: _____

Primary Physician's Name: _____ Phone: _____

Other family members in this practice: _____

How do you wish to be addressed? _____

Consent and Release of Information

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage. By my signature I affirm that the above medical/dental history and other information is true and correct and I realize that I may endanger my health if I have not answered truthfully. I authorize Dr. Barnes, D.D.S.,PC and/or his associates to release any information pertinent to my diagnosis or treatment to any third party participating in my health care or insurance coverage.

I certify that the medical history and information is complete and accurate.

Patient Signature_____ Date _____

Legal Guardian (if not patient) _____ Date _____

Medical History Questionnaire

Name _____ **Date** _____

Thank you for being complete and accurate. This information will remain confidential.

Medical History:

Your last visit to a doctor? _____ Why? _____

Current Physician Name: _____ Phone: _____

LIST ANY MEDICATION/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- ☐ Antibiotics
- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metal/Jewelry
- ☐ Pain Medication
- ☐ Plastic
- ☐ Other

Medical Condition (Please Check those that apply)

- ☐ Acid Reflux/GERD
- ☐ AIDS/HIV
- ☐ Atherosclerosis
- ☐ Arteries/Bleeding
- ☐ Artificial Joints (hip, knee)
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Anemia/Bleeding disorder
- ☐ Blood pressure-High/Low
- ☐ Bleeding Disorders
- ☐ Cancer/Chemotherapy
- ☐ Chemical Addictions/Rx
- ☐ High Cholesterol
- ☐ Chronic Fatigue
- ☐ Cosmetic Surgery
- ☐ Chronic Cough
- ☐ Depression/Anxiety
- ☐ Diabetes/Blood Sugar
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fibromyalgia
- ☐ Glaucoma/Eye Problems
- ☐ Gout
- ☐ Hay Fever/allergy
- ☐ Heart disorder/murmur
- ☐ Head Injury/Concussion
- ☐ Headaches
- ☐ Heart palpitations
- ☐ Heart Disease/Heart Condition
- ☐ Hepatitis
- ☐ Herpes/STD
- ☐ Hypoglycemia
- ☐ Injury to face or neck
- ☐ Insomnia
- ☐ Intestinal disorders/IBS/Crohns
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung conditions
- ☐ Medical marijuana
- ☐ Mental Health Disorders
- ☐ Migraines
- ☐ Muscle spasms/cramps
- ☐ Neck/back/spine conditions
- ☐ Nervous System Conditions
- ☐ Neuralgia
- ☐ Night Sweats/Nightmares
- ☐ Osteoarthritis
- ☐ Osteoporosis (Fosamax, etc.)
- ☐ Pacemaker
- ☐ Psychiatric Care/Counseling
- ☐ Prostate Disease
- ☐ Radiation Treatment
- ☐ Recreational Drugs
- ☐ Rheumatic Fever
- ☐ Sinus problems
- ☐ Sleep apnea/snoring
- ☐ Stroke
- ☐ Supplements/Vitamins
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight loss medication (FenPhen)
- ☐ Other

Other Medications, supplements, substances used regularly: _____

_____

SURGICAL OPERATIONS YOU HAVE HAD (please check those that apply)**:**

- ☐ Digestive System
- ☐ Back or spine
- ☐ Ear Neck
- ☐ Heart
- ☐ Bones or Joints
- ☐ Lung
- ☐ Nasal or Sinus
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Throat or palate
- ☐ Periodontal
- ☐ Brain or Nervous System
- ☐ Oral Surgery

Other: _____

SOCIAL HISTORY:

Tobacco use: Cigarettes ☐ Never Smoked ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew ☐

#packs per day_____ #years_____ Quit: When did you quit? _____

Do you drink: Soda pop ☐ Sparkling water ☐

Alcohol Use: Do you drink alcohol? Yes ☐ No ☐ If yes, # of drinks per week _____

Caffeine Intake: None ☐ Coffee ☐ Tea ☐ Soda ☐ #cups per day _____

Additional: Regular exercise (times per week) _____ Pregnancies_____ #of children_____ Started menopause _____

Signed _____ Date _____

Dental History

Your most recent Dentist: _____ Date of last dental visit: _____

Do you have any dental concerns now? _____

_____

Do you have or have you ever had: (Please check all that apply)

- ☐Orthodontics (braces)
- ☐A splint or nightguard
- ☐Periodontal (gum disease)
- ☐Problems with Novocain
- ☐Complications with dental procedures?
- ☐TMJ Problems
- ☐Painful or bleeding gums
- ☐Jaw joint noises
- ☐Nitrous oxide/Laughing gas
- ☐Problems keeping mouth open
- ☐*Other:

Are you in a field in which your appearance or speech are important? Select...

Have you ever whitened or bleached your teeth? Select...

Do you use an automatic toothbrush? Select...

Are you nervous about dental care? Select...

Do you chew gum regularly? Select...

Do you use breath mints/etc. regularly? Select...

Bite/Jaw Concerns:

- ☐A mismatched bite
- ☐Is it hard to relax your jaw?
- ☐Is your bite uncomfortable?
- ☐Your teeth seem chipped or worn down?
- ☐Clenching
- ☐Grinding
- ☐Difficulty breathing through your nose?
- ☐Do you bite your tongue or cheeks often?

Other_____

Trauma History:

Have you ever been involved in an automobile accident or other trauma (horses, recreational injury, bike etc.)?____

_____

Signed _____ Date _____

PATIENT INSURANCE AND FINACIAL INFORMATION

PATIENT INFORMATION:

Patient Full Name: _____ Male☐ Female☐

INSURANCE INFORMATION:
If you and/or your spouse have dental insurance, please bring the appropriate cards to your appointment. We are happy to submit your insurance without charge; however we do ask that you pay for your appointment at the time of service based on the below requirements. Your signature at the bottom of this document authorizes payment of benefits directly to Dr. Barnes and/or his associates.

AGREEMENT TO FINACIAL RESPONSIBILITY AND POLICIES:
The Federal Truth in Lending Act requires all doctors give their patients information in connection with extension of credit and payment expectations. Please be advised of the following policies, which apply to our office. The responsible party agrees to:

1) Pay at time of service unless there is a previous written agreement on all charges less than $200.00.
2) If payments extend beyond 90 days from the date of service there will be an 18% finance charge assessed monthly. I further agree to pay all legal and/or collection costs reasonably incurred in connection therewith. Interest not paid when due will be added to and become part of the principle balance.
3) A $40.00 charge will be assessed on all returned checks.
4) In the event my insurance company denies coverage for services rendered or does not make a payment within 90 days, I agree to pay the balance in full, including any interest accrued.

IF PATIENT IS A MINOR:
I have legal authority to and hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment. In emergency situations I understand Dr. Barnes and/or his representatives will respond in the best interest of my child. By signing this agreement I am taking responsibility of account payment as ex-spouses/significant others are excluded to be held liable without written permission from said source.

MISSED/BROKEN APPOINTMENTS:
I understand there may be a $40.00 fee per hour, for appointments missed or rescheduled without 48 business hours notice.

By signing below I consent that I have read and agree to the above financial terms in regard to my dental care.

_____ _____
Patient/Responsible Party Signature Date

Updated 4/09

Barnes Dentistry, P.C.
ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name) (Signature) (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

This form is educational only, does not constitute as legal advice, and covers only federal, not state, law (August 14, 2002).

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