PATIENT REGISTRATION

ABOUT YOU

Date: ___________________ Nickname: ___________________________________

Last Name: ___________________________ First: _____________________ MI: ______

Male Female Single Married Child

SS#: ___________________________

Birthdate: _____________________ DL #: ___________________________

Address: ____

City: ___________________________________ State ________ Zip____________

E-Mail: ____

Home #: __________________________ Work #: __________________________

Mobile #: __________________________ Other #: __________________________

Best time and place to call you? ____

Employer: ______________________________ Phone: ______________________

Address: ____

City: ____________________________________ State__________ Zip____________

Who referred you to our office? ____

Other family members seen by us: ____

PERSON RESPONSIBLE FOR ACCOUNT

Skip this section if you are financially responsible for your own account or if any other family members have been seen in our office.

Last Name: ___________________________ First: _____________________ MI: ______

Male Female Single Married

SS#: ___________________________

Birthdate: _____________________ DL #: ___________________________

Address: ____

City: ___________________________________ State ________ Zip____________

E-Mail: ____

Home #: __________________________ Work #: __________________________

Mobile #: __________________________ Other #: __________________________

Best time and place to call you? ____

Employer: ______________________________ Phone: ______________________

Address: ____

City: ____________________________________ State__________ Zip____________

EMERGENCY CONTACT

Closest relative not living with you:

Last Name: ___________________________ First: _____________________ MI: ______

Address: ____

City: ___________________________________ State ________ Zip____________

Home #: __________________________ Work #: __________________________

Mobile #: __________________________ Relation: __________________________

DENTAL INSURANCE

Skip this section if you do not have dental insurance.

PRIMARY INSURANCE

Insurance Carrier: ____

Insurance Address: ____

City: ____________________________________ State ________ Zip____________

Phone #: ____________________________ Group#: __________________________

Subscriber's Name: ________________________________ Relation: ______________

Subscriber's Birthdate: _______________ Subscriber's ID#: _______________________

Subscriber's Employer: ____

Employer's Address: ____

City: ____________________________________ State ________ Zip____________

SECONDARY INSURANCE

Insurance Carrier: ____

Insurance Address: ____

City: ____________________________________ State ________ Zip____________

Phone #: ____________________________ Group#: __________________________

Subscriber's Name: ________________________________ Relation: ______________

Subscriber's Birthdate: _______________ Subscriber's ID#: _______________________

Subscriber's Employer: ____

Employer's Address: ____

City: ____________________________________ State ________ Zip____________

This office will assist me in estimating my insurance benefits and filing insurance claims as a courtesy to me. I accept full responsibility for understanding my insurance coverage, deductibles, limitations and exclusions. I understand that I am responsible for payment of an estimated co-payment and deductible at the time of treatment. Once the insurance claim is processed, there may be a remaining balance. I acknowledge that I am financially responsible for all fees, whether or not paid by my insurance plan.

I hereby assign payment directly to Jim D. McCaskill, DDS, Inc all insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company to secure payment of benefits. I authorize the use of this signature on all insurance claim form submissions.

____

SIGNATURE DATE

ACKNOWLEDGEMENT

Payment in full is due at the time of treatment, unless other arrangements are made in advance. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor or child. I accept full financial responsibility for all fees for services or items provided to me or the patient.

This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I acknowledge receiving a copy of the "Notice of Privacy Practices" of this office.

____

SIGNATURE DATE

Patient Name:______________________________ Date:__________________

MEDICAL HISTORY

Your current physical health is:	Good	Fair	Poor
Do you smoke tobacco?		Yes	No
Do you dip or chew tobacco?		Yes	No

Have you EVER had any of the following?

Abnormal Bleeding	Herpes / Fever Blisters
Alcohol / Drug Abuse	High Blood Pressure
Anemia	HIV+ / AIDS
Arthritis	Hospitalized
Artificial Joints / Heart Valves	Kidney Problems
Asthma	Liver Disease
Blood Transfusion	Low Blood Pressure
Cancer / Chemotherapy	Lupus
Colitis	Mitral Valve Prolapse
Congenital Heart Defect	Pacemaker
Diabetes	Psychiatric Problems
Difficulty Breathing	Radiation Treatment
Emphysema	Rheumatic / Scarlet Fever
Epilepsy	Seizures
Fainting Spells	Shingles
Frequent Headaches	Sickle Cell Disease
Hay Fever	Sinus Problems
Heart Attack	Stroke
Heart Murmur	Thyroid Problems
Heart Surgery	Tuberculosis
Hemophilia	Ulcers
Hepatitis	Venereal Disease

Please list any SURGERIES or other medical conditions:

______________________________ Date______________
______________________________ Date______________
______________________________ Date______________
______________________________ Date______________
______________________________ Date______________
______________________________ Date______________
______________________________ Date______________

FEMALES ONLY:

Are you taking birth control pills?	Yes	No	
Are you pregnant?	Yes	No	Due date:__________
Are you nursing?	Yes	No	

DENTAL HISTORY

Previous Dentist:______________________ Last Visit: __________

Why have you come to the dentist today?______________________________

____

Do you require **antibiotic premedication** prior to receiving any dental treatment? Yes No

Do you have pain or discomfort in your jaw joint (TMJ/TMD)?			Yes	No
Are you currently in pain?			Yes	No
Are your teeth sensitive to:	Biting	Sweets	Hot	Cold

Have you ever had gum surgery or deep scaling?		Yes	No
Do your gums ever bleed?		Yes	No
Your current dental health is:	Good	Fair	Poor
Type of toothbrush used?	Soft	Med	Hard

How often do your floss? ____________ Brush?______________

How long do you use a toothbrush before replacing it? ______________

MEDICATIONS

List any prescription or over-the-counter medications you are taking:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

ALLERGIES

Please list any medical allergies:

Aspirin	Codeine	Dental Anesthetics
Erythromycin	Hydrocodone	Latex
Penicillin	Sulfa	Acetaminophen

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

CERTIFICATION

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____
SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

Provider's Comments: ____

____
____
____
____

I reviewed the medical / dental information above with the patient named herein.

Medical Alerts & Health Questionnaire Updated By:______________

Provider Signature:______________________ Date:______________

This Form Scanned Into Computer By:______________