Patient Registration Information

DAVIS & REESE

Patient Name _____ DOB _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ (H) _____ (W) _____ Cell _____

Do you prefer to receive calls at _____ Home _____ Work _____ Cell? May we leave a message? _____

Would you like to receive text message reminders? _____

Consent to Wireless Telephone Calls

If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from Davis & Reese Dental, its successors and assigns, and its affiliates, agents and independent contractors, including servicers and collection agents, regarding my account, the services rendered, or my related financial obligations. _____

(Patient or Responsible Party Signature)

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Are you: _____ Minor _____ Single _____ Married _____ Divorced _____ Widowed

Insurance Information (please complete all that is applicable)

Name of Insured _____ Relationship to Patient _____ DOB _____

SS#/Subscriber ID _____ Group # _____

Employer _____

Insurance Company Name and Address _____

Insurance Company Customer Service Phone # _____

Secondary Registration Information

Name of Insured _____ Relationship to Patient _____ DOB _____

SS#/Subscriber ID _____ Group # _____

Employer _____

Insurance Company Name and Address _____

Insurance Company Customer Service Phone # _____

As a courtesy, we will accept assignment of your insurance payment, however you are expected to pay your deductible and co-payment at each visit. If you wish to use your dental insurance, you MUST supply complete insurance information and a description of your benefits. Otherwise payment in full will be expected at the time of service. An interest rate of 1.5% per month (18% per annum) will be added to any unpaid balance after 30 days. In the event the patient or responsible party does not pay as herein agreed, and this matter is referred to a collection agency or an attorney for collections, the undersigned agrees to pay the cost of collections including a reasonable attorney's fee.

Responsible Party Information

Responsible Party if other than Patient _____ DOB _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Home Phone _____

Cell Phone _____

Responsible Party Signature _____ Date of Signature _____

(Responsible Party Must be present to Sign)

Patient History Information

DAVIS & REESE

Date _____

Patient Name _____ Patient Date of Birth _____

Name of Family Physician _____ Physician's Phone Number _____

Date of Last Dental Exam _____ Date of Last Dental Cleaning _____

Emergency Contact _____ Emergency Contact Phone No. _____

Do you have a history of any of the following conditions?

	Yes	No		Yes	No
Blood Disorder/Abnormal Bleeding	( )	( )	Epilepsy/Seizures	( )	( )
Heart Condition	( )	( )	Fainting or Dizziness	( )	( )
High Blood Pressure	( )	( )	Thyroid Disease	( )	( )
Heart Murmur	( )	( )	Sinus Trouble	( )	( )
Artificial Heart Valve	( )	( )	Liver or Kidney Disease	( )	( )
Rheumatic Fever	( )	( )	Hepatitis	( )	( )
Blood Transfusion	( )	( )	Asthma	( )	( )
Pacemaker	( )	( )	Emphysema	( )	( )
Heart Surgery	( )	( )	Lung Disease	( )	( )
Heart Attack	( )	( )	Tuberculosis	( )	( )
Anemia	( )	( )	HIV/AIDS	( )	( )
Cortisone/Steroid Medication	( )	( )	HPV - Human Papillomavirus	( )	( )
Stroke	( )	( )	History of Drug or Alcohol Addiction	( )	( )
Diabetes	( )	( )	Mental Health Treatment	( )	( )
ALLERGIES			Radiation of Head/Neck	( )	( )
Penicillin	( )	( )	Cancer	( )	( )
Codeine or Aspirin	( )	( )			
Local Anesthetic, "Caines"	( )	( )			
Others	( )	( )			

Please List _____

Do you have any disease, conditions or problems not listed above? If yes, please list _____

_____

Have you had any serious illness or surgery? Please list _____

Please list all medications you are currently taking, including over the counter medications _____

_____

If you are female, are you taking Birth Control Pills? _____

Have you had Joint Replacement surgery? _____

Have you ever taken any drugs for osteoporosis or other bone disorder (ex. Fosamax, Acetonel)? _____

Have you ever taken any IV forms of bisphosphonates (ex. Aredia, Zometa)? _____

Do you take blood thinners or Aspirin on a daily basis? If yes, please list _____

Are you required to take pre-medication prior to dental treatment? _____