# Patient Registration

Current Date: ___/___/____

First Name______________________ Last Name_____________________________ MI_____
Responsible Party (If someone other than the patient): Name ____________________________

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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_______________________



Signed______________________________ 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 CAUSES AN ALLERGIC REACTION:**

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

**Medical Condition (Please Circle 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
Blood sugar problems
Bleeding Disorders
Cancer/Chemotherapy
Chemical Additions/Tx
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/Nighmares
Osteoarthritis
Osteoporosis (Fosamax, etc)
Pacemaker
Psychiatric Care/Counseling
Prostate Disease
Radiation Treatment
Recreational Drugs/Steroids
Rheumatic Fever
Sinus problems
Sleep apnea/snoring
Stroke
Supplements/Vitamins
Swelling
Prescription medications
Thyroid disorder
Tuberculosis
Ulcers
Weight loss medication (FenPhen)
Other

Other Medications, supplements, substances used regularly: __________________________________________
______________________________________________________________________________________

## SURGICAL OPERATIONS YOU HAVE HAD (please circle 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? ________________If yes, # of drinks per week______________________

Caffeine Intake: None Coffee/Tea/Soda #cups per day________________________________

Additional: Regular exercise__________ Pregnancy________ #of children____________________________

Started in 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 circle 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?

___Have you ever whitened or bleached your teeth?

___Are you nervous about dental care?

___Do you use breath mints/etc. regularly?

___Do you use an automatic toothbrush?

___Do you chew gum regularly?

## 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

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## 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
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify)

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Signed_______________________________ Date_______________________