

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
 E-mail: _____ I would like to receive correspondences via e-mail.

Section 2 | Section 3

Employment Status: Full Time Part Time Retired
 Student Status: Full Time Part Time
 Medicaid ID: _____ Pref. Dentist: _____
 Employer ID: _____ Pref. Pharmacy: _____
 Carrier ID: _____ Pref. Hyg: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: _____ Rem. Deduct: _____

Monroe Family Dentistry Medical/Dental History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes

Have you been hospitalized? Yes No If yes

Have you had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Any knee, hip, shoulder, ankle replacements? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications for bone density disorders? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Iodine

Sedatives

Do you have any other allergies? Yes No If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sidde Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed above? Yes No If yes

Dental History

Have you seen a dentist previously? If yes please list name and Location

Yes No

If yes

Date of Last Dental Exam

Do your gums bleed while brushing or flossing?

Yes No

If yes

Are your teeth sensitive to hot or cold liquids/foods?

Yes No

If yes

Are your teeth sensitive to sweet or sour?

Yes No

If yes

Do you feel pain to any of your teeth?

Yes No

If yes

Any sores/lumps in or near your mouth?

Yes No

If yes

Have you had any head, neck or jaw injuries?

Yes No

If yes

Have you ever experienced any of the following problems in your jaw?

Clicking Yes No

Pain (joint, ear, side of face) Yes No

Difficulty in opening or closing Yes No

Difficulty in chewing Yes No

Do you have frequent headaches?

Yes No

If yes

Do you clench or grind your teeth?

Yes No

If yes

Do you bite your lips or cheeks frequently?

Yes No

If yes

Have you ever had any difficult extractions?

Yes No

If yes

Have you ever had any prolonged bleeding following extractions?

Yes No

If yes

Have you had any orthodontic treatment?

Yes No

If yes

Do you wear dentures or partials? Date placed?

Yes No

If yes

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

Yes No

If yes

Do you dislike your smile? What do you not like?

Yes No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

MONROE FAMILY DENTISTRY

John R. Monroe, DMD

4018 E. North Street

Greenville, SC 29615

OFFICE POLICY

We appreciate the confidence you have placed in our office to provide you with your dental needs.

Appointments We have a variety of appointment times available and we are happy to make appointments for you at times that are convenient for your schedule. We value your time as well as ours. If you must change your appointment, we ask that you give us **24 hours notice** to do so otherwise there will be a \$50.00 charge for the broken appointment.

Insurance We will gladly file your insurance for you. You are responsible for keeping our office informed of any changes in the insurance coverage. You are responsible for any and all procedures not covered by your insurance.

Payment for Services We accept cash, checks, Visa, Mastercard, Discover and American Express. We also offer *Care Credit* as our payment plan and will be glad in assisting you with this option. If payment is not received for services and your account is referred to a collection agency, you will be responsible for collection fee. Collection fee is 25% of total amount due in addition to total balance.

Signature of Patient: _____

Date: _____

**Monroe Family Dentistry
4018 E. North Street
Greenville, SC 29615
(864) 268-0936**

**HIPPA
(Health Insurance Portability and Accountability Act)**

How We May Use and Disclose Medical Information About You

For Treatment: We may use medical information about you to provide you with medical treatment and services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

I certify that I have read the above statement concerning this office's privacy practices.

(Please print name)

(Signature)

(Date)

Please list the name or names of persons that you allow to discuss your dental care.
