

Please complete and return in self addressed stamped envelope along with a copy (front & back) of your insurance card.

PATIENT REGISTRATION

Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

Randy G. Fussell, DDS
Taylor E. Humphreys, DDS
C. Holt Humphreys, DDS
Adam C. Harrell, DDS

1 About You

Today's Date: _____

Name: Mr. Mrs. Ms. Dr. _____
(LAST) * (FIRST) (MI)

I prefer to be called: _____ License # _____

Birthdate: _____ Age: _____ S.S. # _____

Street Address Necessary: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ County: _____

Male Female Single Married Divorced Widowed

Home Phone #: _____ Email Address: _____

Work Phone #: _____ Ext. _____ Cell # _____

Where and when are the best times to reach you from 8 am - 4 pm? _____

Choose preferred method of confirming appointment: Email Text Telephone

Employer: _____

Employer's Address : _____

How long have you worked there? _____ Occupation: _____

Is another family member or relative a patient in our office? _____

Name: _____ Relationship: _____

2 About Your Spouse

His/Her Name _____

Employer: _____ Occupation: _____

Work Phone #: _____ Ext.: _____ Cell # _____

3 Account Information

Person Financially Responsible for Account: _____

Relationship to Patient: _____ S.S. #: _____

Billing Address: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Employer: _____

If 18 or older and you are not responsible for acct., authorize permission to discuss treatment/acct. with person responsible.

Signature _____

④ Emergency Contact

In the event of an emergency, whom should we contact? _____

Relation: _____ Home Phone #: _____ Work Phone #: _____

2nd contact (not living with you): _____

Relation: _____ Home Phone #: _____ Work Phone #: _____

⑤ Referral Source

Our practice is fortunate to receive referrals from friends (patients and colleagues) who have been pleased with the services that we provide. Whom may we thank for referring you to us? _____

⑥ Dental Insurance

Insurance Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group #: _____ ID # _____

Name of Policy Holder: _____ Relation: _____

Birthdate of Policy Holder: _____ Policy Holder's S.S. #: _____

Policy Holder's Employer: _____ Date Employed: _____

Are you eligible for direct reimbursement benefits? Yes No

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

⑦ Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1 1/2 % per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note. I agree to any inquiries as deemed necessary to establish credit with the office. Including a formal credit review. I hereby authorize payment of my dental insurance benefits directly to Drs. Fussell, Humphreys, Humphreys & Harrell. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

Signature of patient, parent, or guardian Date: _____ Relationship to patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to patient: _____

MEDICAL HISTORY

Primary Physicians name: _____ Phone: _____
 Address _____ City _____ State _____ Zip _____
 Have you ever been under the care of a physician during the past two years other than routine visits? Yes No _____
 If yes, for what? _____
 Are you currently taking any medications or supplements? Yes No _____
 List _____
 Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No _____
 Explain _____
 Have you been a patient in the hospital during the past 5 years? Yes No _____
 Name and phone number of your preferred pharmacy _____

Are you being treated or ever been treated for:

An abnormal heart condition of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specify _____	Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac transplant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease/problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease/problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial endocarditis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic disorders?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valve?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis [] A (infectious), [] B (serum), [] C <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints (hip, knees, shoulders, etc.)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	A.I.D.S., or H.I.V. positive?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease/ Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal bleeding from a cut? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any family history of heart disease or stroke? Yes No
 If yes, explain _____
 Do you have or have you had any disease, condition or problem not listed above? Yes No
 If yes describe _____
 Are you a smoker? Yes No
 Do you have any allergic skin reactions to metal jewelry?..... Yes No
 Have you ever been told that you require premedication with antibiotics
 prior to dental treatment? Yes No

Women:

Are you pregnant? Yes No
 Nursing? Yes No
 Taking Birth Control Pills? Yes No

I authorize Permission to discuss Pre-med with family member or leave messages

Signature _____

CONSENT FOR TREATMENT

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner, I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Fussell, Humphreys, Humphreys & Harrell of any changes in my health or medication. The undersigned hereby authorizes Fussell, Humphreys, Humphreys & Harrell to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Fussell, Humphreys, Humphreys & Harrell to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. All diagnostic aids and documentation are the property of the practice. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another healthcare provider.

I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

DENTAL HISTORY

Please answer the following questions accurately to permit us to treat you appropriately based on your particular needs. Your answers are confidential and will be used for our records only.

What is the reason for your visit today? _____

Reason for changing dental office? _____

Date of your last dental visit _____ Previous Dentist's name _____

What was done at your last dental visit? _____

When were last xrays taken? _____

How often do you have dental examinations? _____

How often do you brush? _____ Brush is: [] Soft [] Medium [] Hard

How often do you floss? _____

What other oral hygiene aids do you use? _____

Are you having any discomfort at this time? [] Yes [] No

If yes, please describe _____

Have you ever had any unpleasant experiences associated with previous dentistry? [] Yes [] No

If yes, please describe _____

Are you nervous about having dental treatment? [] Yes [] No

If yes, please describe _____

Do you have any of the following?

Teeth sensitive to [] hot, [] cold, [] biting, [] sweets? [] Yes [] No

Frequent mouth odors or bad tastes? [] Yes [] No

Frequent cold sores, blisters, etc. in your mouth? [] Yes [] No

Swelling or lumps in your mouth? [] Yes [] No

Gums that [] bleed, [] are sore, [] are swollen? [] Yes [] No

Loose teeth? [] Yes [] No

A change in your bite or the way your teeth come together? [] Yes [] No

Food packing between your teeth? [] Yes [] No

Clicking or popping in your jaws? [] Yes [] No

Difficulty in opening or closing your mouth? [] Yes [] No

Frequent headaches, neck aches or shoulder aches? [] Yes [] No

Have you ever had any of the following?

Periodontal (gum) treatment? [] Yes [] No

If yes, type of treatment _____

Orthodontic treatment (braces)? If so, when? [] Yes [] No

A bite plate or mouthguard made? [] Yes [] No

Your teeth ground or bite adjusted? [] Yes [] No

Is there anything else about having dental treatment you would like us to know?

[] Yes [] No

If yes, please describe _____

