

Franklin Smiles

Patient Registration



J A Reynolds DDS
COSMETIC AND RESTORATIVE DENTISTRY



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Faculty

Welcome!

We are dedicated to the concept that all people have the opportunity to retain their teeth throughout their lifetime with optimum health, function, comfort and esthetics. We realize the importance of your smile and are committed to offering the best that dentistry has to offer-providing quality restorative dentistry with special emphasis on cosmetics. Thanks for coming!

PATIENT INFORMATION

Last Name: _____ First Name: _____
Gender: ___ M ___ F Marital Status: ___ Married ___ Single ___ Other
Date of Birth: _____ Social Security #: _____
Email Address: _____
Home Address: _____ City: _____ ST: _____ Zip: _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____

How did you hear about our office? _____

DENTAL INSURANCE

(Medical insurance does not apply-provide dental insurance information only)

Name of Employer: _____
Name of Subscriber: _____ Subscriber ID: _____
Subscriber Date of Birth: _____ Group #: _____

Name of Insurance Company: _____

Mailing Address for Dental Claims:

City: _____ ST: _____ Zip: _____

Phone: _____

MEDICAL HISTORY (circle all that apply)

Allergies	Excessive Bleeding	High Blood Pressure	Radiation Treatment
Anemia	Fainting	Jaundice	Respiratory Problem
Artificial Joints	Glaucoma	Kidney Disease	Rheumatic Fever
Blood Disease	Growths	Liver Disease	Sinus Problems
Cancer	Head Injuries	Mental Disorders	Stomach Problems
Diabetes I or II	Heart Disease	Mitral Valve Prolapse	Stroke
Dizziness	Heart Murmur	Muscular Dystrophy	Thyroid Problems
Epilepsy	Hepatitis	Pacemaker	Tuberculosis

Other: _____

DRUG ALLERGIES or Other Allergies (circle all that apply)

Amoxicillin	Codeine	Local Anesthetic	PENICILLIN
Ampicillin	Erythromycin	Mercury	Sulfa
Anaprox	Keflex	Morphine	Tetracycline
Aspirin	LATEX	Motrin	

Other: _____

ARE YOU TAKING ANY MEDICATIONS? ___ Yes ___ No (If yes, list below)

<i>Name of Drug</i>	<i>Dosage</i>	<i>Reason for Taking</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOR WOMEN ONLY

Are you pregnant? ___ Yes ___ No (If yes, when are you due? _____)

Are you nursing? ___ Yes ___ No

Are you taking birth control pills? ___ Yes ___ No

DENTAL HISTORY

Date of Last Cleaning/Exam _____

Name of previous dentist: _____

Have you ever had orthodontics, periodontal surgery, or other major medical treatment? If yes, explain:

What would you like Dr. Reynolds to do for you? List any items you wish to discuss with Dr. Reynolds:

Please indicate yes or no (Y/N) to the following:

- ___ Do you use any form of tobacco?
- ___ Do you have any areas where food impacts around your teeth?
- ___ Do your gums tend to bleed easily, feel irritated or tender?
- ___ Are your teeth sensitive to hot, cold, pressure or sweets?
- ___ Do you have pain in your head, neck, shoulder, or upper back?
- ___ Do you have popping, clicking, or other noises in your jaw joints?
- ___ Are you aware of grinding or clenching your teeth?
- ___ Have you ever had any negative reactions to a dental injection or nitrous oxide?
- ___ Are you anxious or nervous about dental treatment?

On a scale of 1-10, how concerned are you with the appearance of your smile? _____ (1=Not concerned at all; 10=VERY concerned)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form I am consenting to the use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations. I understand that the information above is necessary to provide dental care in a safe and efficient manner. The answers provided above are correct and complete.

By signing this form, you agree to inform this office of any changes in your medical history. Your signature indicates you understand that Dr. Reynolds is HIPPA compliant and all precautions will be taken to protect your privacy.

ACCOUNT INFORMATION

By signing this form, I understand the financial responsibility for dental services provided in this office for myself and/or my dependents is mine. Insurance is filed as a courtesy and I understand I will pay any estimated portions and any portions not paid by insurance. I further understand payment is due at time of service.

DENTAL INSURANCE

By signing this form, I agree to provide current and correct insurance information to Dr. Reynolds. I agree to pay the estimated patient portion at the time of service. I understand that any balance NOT paid by insurance is my full responsibility.

I understand Dr. Reynolds is not a contracted provider with any insurance company and it is my responsibility to research my policy for limitations regarding out-of-network providers.

***I understand if the insurance company has not provided payment within 60 days of the submission date, the claim will be closed and the remaining balance becomes my full responsibility.**

PLEASE SIGN BELOW:

Signature indicates you have read, and agree, with the items above:

Signature: _____ **DATE** _____

PARENT OR GUARDIAN

If patient is a child, please read & sign below:

I understand that the information above is necessary to provide my child with dental care in a safe and efficient manner. To my knowledge answers are correct and complete. Realizing that the use of anesthetic agents embodies certain risks, I will inform this office of any changes in my child's medical history. I further authorize and consent that Doctor Reynolds and/or his assigned may utilize diagnostic aids deemed appropriate and perform all forms of treatment, medication, and therapy deemed necessary in connection with the dental care of patient until written notice is given discontinuing this permission.

Patient or Guardian Signature _____ **Date** _____

Relationship to Patient _____