



PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Dr. Mr. Mrs. Ms. Rev. Other

Gender: Male Female Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Are you: Minor Married Single Divorces Widowed Separated

Driver's Lic No.: _____ SSN No.: _____

Spouse's Name: _____

Spouse's Occupation: _____ Spouse's Work Phone: _____

Is Patient a full time student? Yes No Name of school: _____

RESPONSIBLE PARTY (if different than patient)

First Name: _____ Last Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ SSN No.: _____

Relationship to Patient: _____

YOUR PREFERENCES

Do you prefer appointment reminder by: Email Phone Text

Do you prefer to receive calls from our office at: Home Work Cell

How did you hear about our office? _____

How do you wish to be addressed by our team members? _____



INSURANCE INFORMATION

DENTAL INSURANCE:

Subscriber's Name: _____ Relationship to patient: _____

Date of birth: _____ Subscriber's ID No.: _____

Insurance Company: _____ Policy No.: _____ Group: _____

SECONDARY INSURANCE (DENTAL):

Insured Name: _____ Relationship to patient: _____

Address: _____

Date of birth: _____ ID No. : _____ Employer: _____

Insurance Company: _____ Group No.: _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes No

Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Physician Name: _____ Physician Phone No.: _____

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

Have you ever been hospitalized or had a major operation? Yes No

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
 Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you take or need antibiotics before dental procedures? Yes No

[Women] Are you.. Pregnant/Trying to get pregnant Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- | | | | |
|----------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metal | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Latex |



Any other allergies? _____

Do you have or have ever had:

- Cancer
- Rheumatic/Scarlet Fever
- HIV/AIDS
- Swelling of Limbs
- Hives or Rash
- Tumors or Growths
- Fatigued/Tired
- Joint Replacement
- Recent Trauma/Injury
- Shingles
- General Weakness
- Liver Problems
- Recent Weight Loss
- Frequent Headaches
- Chemotherapy
- Excessive Thirst
- Radiation Treatments

Cardiovascular System

- Artificial Heart Valve
- High Blood Pressure
- Tachycardia
- Chest Pain or Angina
- Low Blood Pressure
- Congenital Heart Defect
- Heart Attack
- Mitral Valve Prolapse
- Heart Murmur
- Congestive Heart Failure
- Pacemaker
- High Cholesterol

Endocrine

- Diabetes
- Thyroid Problems
- Hormonal Change
- Hypoglycemia

Eyes, Ears, Nose, Throat

- Change in Hearing
- Glaucoma
- Sinus Problems
- Change in Vision
- Difficulty Swallowing
- Hay Fever
- Tonsillectomy
- Nasal Obstruction
- Ringing in Ears (Tinnitus)
- Ear Pain
- Nose Bleeding

Gastrointestinal

- Acid Reflux
- Stomach/Intestinal Disease
- GERD
- Frequent Diarrhea
- Soft of Special Diet
- Ulcers

Comments

Genitourinary

- Frequent Urination
- Renal Dialysis
- Kidney Problems
- Venereal Disease
- Nocturia(Bed)
- Genital Herpes



Hematological

- Bleeding Problems
- Anemia
- Hepatitis
- Leukemia
- Blood Disease
- Blood Transfusion
- Hemophilia
- Bruise Easily

Musculoskeletal

- Back Pain
- Osteoporosis
- Fibromyalgia
- Spina Bifida
- Arthritis/Gout
- Muscle Weakness
- Rheumatism

Neurological

- Alzheimer's Disease
- Epilepsy or Seizures
- Dizziness/Fainting
- Tremor
- Parkinson's Disease
- Tingling/Numbness
- Memory Loss
- Stroke
- Convulsions
- Multiple Sclerosis
- Trigeminal Neuralgia

Oral

- Bleeding Gums
- Jaw Joint Pain
- Teeth denching/grinding
- Canker Sores
- Dry Mouth
- Difficulty Chewing
- Tooth Pain
- Cold Sores/Fever Blisters
- Jaw Joint Problems
- Difficulty Chewing
- Orthodontics / Invisalign
- Wisdom Teeth Extraction
- Jaw Joint Clicking
- Periodontal Disease
- Have Removable Teeth

Psychiatric

- ADD/ADHD
- Eating Disorders
- Anxiety
- Excessive Stress
- Chemical Dependency
- Memory Problems
- Depression
- Psychiatric Care

Respiratory

- Asthma
- Emphysema
- Lung Disease
- Bronchitis
- Easily Winded/Dyspnea
- Tuberculosis
- Breathing Problems
- Pneumonia
- Congestion
- Frequent Cough

Sleep

- Daytime Sleepiness
- Snoring
- Morning Headaches
- Obstructive Sleep Apnea
- Do you use a CPAP
- Have you ever had any serious illness not listed above?

Comments



GENERAL CONSENT TO DIAGNOSE AND TREAT

The undersigned hereby authorizes Keith W. Kelley DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Keith W. Kelley, DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Keith W. Kelley, DDS choose and employ such assistance as deemed necessary. I understand that the use of anesthetic agents embodies certain risks and consent to their use as deemed appropriate by Keith W. Kelley, DDS. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT

I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. This office will not bill a non-custodial parent. I understand that I am responsible for any portion of fees for service rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 7% annual finance charge that will be applied to any balance over 30 days; returned checks will incur a \$25.00 fee. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Keith W. Kelley, DDS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Signature of Patient, Parent or Guardian: _____

Date : _____

NOTICE OF PRIVACY PRACTICES

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practice's policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

Patient Signature: _____

Date: _____