TIME 12:04 PM

DATE 10/24/2018

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

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:

Section 3

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

_____, _____, _____

MONROE FAMILY DENTISTRY
John R. Monroe, DMD, PA
4018 East North Street
Greenville, SC 29615
(864) 268-0936

Consent for X-rays

I, _____, authorize for my x-rays to be released to the office of John R. Monroe, DMD.

Signature: _____

Patient Date of Birth: _____

Today's Date: _____

Please email x-rays to: info@monroefamilydentistry.com