

PATIENT REGISTRATION

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: _____
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: _____
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: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired	Referred By _____
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Previous Dentist _____
Employer ID: _____ Pref. Dentist: _____	Emergency Contact _____
Carrier ID: _____ Pref. Pharmacy: _____	Emergency Contact # _____
Pref. Hygienist: _____	

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Group #: _____ Member ID #: _____ Policy ID #: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Group #: _____ Member ID #: _____ Policy ID #: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Medical History Form

Patient Name: _____ Emergency Contact _____
Date of Birth: _____ Emergency Contact Phone _____
Sex: _____ Emergency Contact Relationship _____

Do you have any of the following diseases or problems

- Active Tuberculosis Yes No
Persistent cough greater than a 3 week duration Yes No
Cough that produces blood Yes No
Been exposed to anyone with tuberculosis Yes No

Medical History

Are you now under the care of a physician? Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

Do you wear contact lenses? Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? Yes No

Nursing? Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics Yes No

Aspirin Yes No

Penicillin or other antibiotics Yes No

Barbiturates, sedatives, or sleeping pills Yes No

Sulfa drugs Yes No

Codeine or other narcotics Yes No

Metals Yes No

Latex (rubber) Yes No

Iodine Yes No

Hay fever/seasonal Yes No

Animals Yes No

Food Yes No

Other Yes No

If Other, please specify:

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve Yes No

Previous infective endocarditis Yes No

Damaged valves in transplanted heart Yes No

Congenital heart disease (CHD) Yes No

Unrepaired, cyanotic CHD Yes No

Repaired (completely) in the last 6 months .. Yes No

Repaired CHD with residual defects Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease Yes No

Angina Yes No

Arteriosclerosis Yes No

Congestive heart failure Yes No

Damaged heart valves Yes No

Heart attack Yes No

Heart murmur Yes No

Low blood pressure Yes No

High blood pressure Yes No

Other congenital heart defects Yes No

Mitral valve prolapse Yes No

Pacemaker Yes No

Rheumatic fever Yes No

Rheumatic heart disease Yes No

Abnormal bleeding Yes No

Anemia Yes No

Blood transfusion Yes No

If yes, date _____

Hemophilia Yes No

AIDS or HIV Yes No

Arthritis Yes No

Autoimmune disease Yes No

Rheumatoid arthritis Yes No

Systemic lupus erythematosus Yes No

Asthma Yes No

Bronchitis Yes No

Emphysema Yes No

Sinus trouble Yes No

Tuberculosis Yes No

Cancer/Chemotherapy/Radiation Treatment Yes No

- Chest pain upon exertion Yes No
- Chronic pain Yes No
- Diabetes Type I or II Yes No
- Eating disorder Yes No
- Malnutrition Yes No
- Gastrointestinal disease Yes No
- G.E. Reflux/persistent heartburn Yes No
- Thyroid problems Yes No
- Stroke Yes No
- Glaucoma Yes No
- Hepatitis, jaundice or liver disease Yes No
- Epilepsy Yes No
- Fainting spells or seizures Yes No
- Neurological disorders Yes No

If yes, please specify _____

- Sleep disorder Yes No
- Mental health disorders Yes No
- Specify _____
- Recurrent infections Yes No
- Type of infection _____
- Kidney problems Yes No
- Night sweats Yes No
- Osteoporosis Yes No
- Persistent swollen glands in neck Yes No
- Severe headaches/migraines Yes No
- Severe or rapid weight loss Yes No
- Sexually transmitted disease Yes No
- Excessive urination Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Please explain _____

Signature of Patient/Legal Guardian

Wesley Cooksey, D.D.S

We would like to welcome you to our practice! We are dedicated to providing you with the finest dental treatment available. Your comfort is our first concern.

If you have dental insurance coverage, it is important that the patient understands his or her coverage, including financial responsibility. As a courtesy, we will file insurance and we can accept assignment of benefit payments from most insurance companies. The portion that your insurance does not cover is your responsibility. Please note that dental insurance is not a guarantee of payment. Balance not covered by insurance will be the patient's responsibility. Please be advised that insurance companies cover amalgam (silver) and resin (white) fillings differently, resin costing slightly more. All insurance policies may cover different percentages, so again, please be aware of your individual insurance regulations. _____(initials)

I hereby authorize the Dr. or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the Dr. to make a thorough diagnosis of my needs. _____(initials)

Upon such diagnosis, I authorize the Dr. to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies certain risk. _____(initials)

Cavities: Amalgam (silver) These silver, mercury fillings are the least expensive and often last much longer, especially in back teeth where your bite is the strongest. Some people are concerned because mercury is formulated in these fillings; however, it has not been proven to be a health risk. Resin (tooth colored) These function the best in front teeth and work well in areas where they don't get a lot of biting force on them. The smaller they are, the longer they last. All fillings must be replaced in time. Large fillings may need to be replaced with crowns. Deep fillings may irritate the tooth's nerves and result in the need for a root canal to stop your discomfort and save the tooth.

Crowns: Crowns will take two appointments. They are as close to being a permanent restoration that we can make. You must still clean and take care of a crowned tooth or it can get a cavity. A crowned tooth may develop nerve damage and result in the need of a root canal to save the tooth.

Root canals: Root canals save sensitive, painful, loose, abscessed teeth 96% of the time successfully. These teeth could require surgery or even be lost. Most of these teeth require a crown to save the tooth. Rare complications of treatment includes: pain and swelling, damage to existing filling or crown, root fracture, overfill or underfill, and root perforation.

I understand delay or denial of treatment may aggravate these conditions and result in changes in the proposed treatment. I have been informed of the above conditions, treatment options and risks involved. I understand I will be given the opportunity to ask questions concerning my condition and treatment.

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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