

PATIENT REGISTRATION

PLEASE USE INK

Date _____

JOHN A. GHOLSON III, DDS

C. ASHLEY CLAYTON, DDS

Patient's Name _____

(LAST, FIRST, MIDDLE)

Address _____

(NUMBER AND STREET)

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Patient employed by _____ Phone _____

Employer's Address _____

(NUMBER AND STREET)

(CITY, STATE, ZIP)

Social Security Number _____ Sex _____ Date of Birth _____

Marital Status: Married _____ Single _____ Widowed _____ Separated _____ Divorced _____ Name of Spouse _____

Spouse's place of employment _____ Phone _____

Employer's Address _____

(NUMBER AND STREET)

(CITY, STATE, ZIP)

Whom may we thank for referring you _____

In case of emergency, who may we contact, not in your household _____ Phone _____

Relationship to patient _____

Who will pay this account _____ Method of Payment _____

Do you have insurance that may cover any part of our professional services? Yes _____ No _____

Primary Insurance Company _____

Policy Number _____ Group Number _____

Secondary Insurance Company _____

Policy Number _____ Group Number _____

I understand that regardless of my insurance status, I am ultimately and primarily responsible for the balance of the account and for any professional services rendered.

DENTAL / MEDICAL HISTORY

1. Date of last dental treatment _____ Purpose _____

Was treatment completed?..... Yes No

2. Date of last cleaning _____ Date of last dental X-rays _____

3. List main dental complaint(s): _____

4. Are you happy with the cosmetic appearance of your teeth?..... Yes No

5. If no, why? _____

6. Have you been under the care of a physician or in a hospital during the past 2 years?..... Yes No

For _____

7. Have you ever had any medical radiation treatment?..... Yes No

8. Have you ever taken a Bisphosphonate derivative medication? (Fosamax, Aredia)..... Yes No

9. Are you currently taking any type of blood thinner medication? (Coumadin, Warfarin, Plavix, Aspirin)... Yes No

If so, what? _____

10. Have you taken any kind of medicine(s) or drugs during the past year?..... Yes No

If so, what? _____

11. Are you allergic to penicillin or any drugs or medicine?..... Yes No

If so, what? _____

12. Have you ever had any excessive bleeding requiring special treatment?..... Yes No

13. Have you had a test for HIV infection?..... Yes / No..... If so..... Positive / Negative

14. Circle any of the following which you have had or now have:

- | | | | | |
|-------------------------|--------------------------|---------------|-----------------------|-----------------------|
| AIDS | Asthma | Diabetes | Herpes | Psychiatric Treatment |
| Allergies | Cancer Treatment | Epilepsy | High Blood Pressure | Rheumatic Fever |
| Anemia | Cardiac Pacemaker | Heart Murmur | Jaundice | Sinus Trouble |
| Arthritis | Congenital Heart Lesions | Heart Trouble | Kidney Treatment | Stroke |
| Artificial Heart Valves | Cough | Hepatitis | Latex Allergy | Tuberculosis |
| | | | Mitral Valve Prolapse | Thyroid Disease |

15. Have you had any other serious illnesses?..... Yes No

16. If female, are you pregnant now?..... Yes / No..... Taking birth control pills..... Yes No

Name of your physician _____ Address _____

Last seen _____ Phone _____

I am seeking dental treatment in this office and verify, that to the best of my knowledge, the above information is accurate.

Reviewed by _____ Date _____ Signature _____

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