Please complete and return in self addressed stamped envelope along with a copy (front & back) of your insurance card.

PATIENT REGISTRATION

Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

Randy G. Fussell, DDS
Taylor E. Humphreys, DDS
C. Holt Humphreys, DDS
Adam C. Harrell, DDS

① About You

Today's Date: ______________________

Name: Mr. Mrs. Ms. Dr. ______________________ (LAST) (FIRST) (MI)

I prefer to be called: ______________ License # ______________

Birthdate: ______________ Age: ______________ S.S. # ______________

Street Address Necessary: ______________ P.O. Box: ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone #: ______________ Email Address: ______________

Work Phone #: ______________ Ext. ______________ Cell # ______________

Where and when are the best times to reach you from 8 am - 4 pm? ______________

Choose preferred method of confirming appointment: ❑ Email ❑ Text ❑ Telephone

Employer: ______________

Employer's Address : ______________

How long have you worked there? ______________ Occupation: ______________

Is another family member or relative a patient in our office? ______________

Name: ______________ Relationship: ______________

② About Your Spouse

His/Her Name ______________

Employer: ______________ Occupation: ______________

Work Phone #: ______________ Ext.: ______________ Cell # ______________

③ Account Information

Person Financially Responsible for Account: ______________

Relationship to Patient: ______________ S.S. #: ______________

Billing Address: ______________

Home Phone #: ______________ Work Phone #: ______________ Ext: ______________

Employer: ______________

If 18 or older and you are not responsible for acct., authorize permission to discuss treatment/acct. with person responsible.

Signature ______________

④ Emergency Contact

In the event of an emergency, whom should we contact? ____________________

Relation: ____________ Home Phone #: ____________ Work Phone #: ____________

2nd contact (not living with you): ____________________

Relation: ____________ Home Phone #: ____________ Work Phone #: ____________

⑤ Referral Source

Our practice is fortunate to receive referrals from friends (patients and colleagues) who have been pleased with the services that we provide. Whom may we thank for referring you to us? ____________________

⑥ Dental Insurance

Insurance Co. Name: ____________________

Ins. Co. Address: ____________________

Ins. Co. Phone #: ____________________

Group #: ____________ ID # ____________

Name of Policy Holder: ____________ Relation: ____________

Birthdate of Policy Holder: ____________ Policy Holder's S.S. #: ____________

Policy Holder's Employer: ____________ Date Employed: ____________

Are you eligible for direct reimbursement benefits? ❑ Yes ❑ No

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

⑦ Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1 1/2 % per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note. I agree to any inquiries as deemed necessary to establish credit with the office. Including a formal credit review. I hereby authorize payment of my dental insurance benefits directly to Drs. Fussell, Humphreys, Humphreys & Harrell. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

____________________ Date: ____________ Relationship to patient: ____________

Signature of patient, parent, or guardian

____________________ Date: ____________ Relationship to patient: ____________

Signature of guarantor of payment/responsible party

MEDICAL HISTORY

Primary Physicians name: ______________________ Phone: ______________

Address ______________________ City ______________________ State ______________ Zip ______________

Have you ever been under the care of a physician during the past two years other than routine visits? ❑ Yes ❑ No ______________

If yes, for what? ______________________

Are you currently taking any medications or supplements? ❑ Yes ❑ No ______________

List ______________________

Are you aware of having an allergic or adverse reaction to any medication or substance? ❑ Yes ❑ No ______________

Explain ______________________

Have you been a patient in the hospital during the past 5 years? ❑ Yes ❑ No ______________

Name and phone number of your preferred pharmacy ______________________

Are you being treated or ever been treated for:

An abnormal heart condition of any kind? ❑ Yes ❑ No

Specify ______________________

Cardiac transplant? ❑ Yes ❑ No

Congenital heart disease? ❑ Yes ❑ No

Bacterial endocarditis? ❑ Yes ❑ No

Artificial heart valve? ❑ Yes ❑ No

Hepatitis [ ] A (infectious), [ ] B (serum), [ ] C ❑ Yes ❑ No

Artificial joints (hip, knees, shoulders, etc.)? ❑ Yes ❑ No

Kidney disease/ Dialysis? ❑ Yes ❑ No

Arthritis/Rheumatism? ❑ Yes ❑ No

Rheumatic Fever ❑ Yes ❑ No

High Blood Pressure? ❑ Yes ❑ No

Diabetes? ❑ Yes ❑ No

Thyroid disease/problems? ❑ Yes ❑ No

Respiratory disease/problems? ❑ Yes ❑ No

Neurologic disorders? ❑ Yes ❑ No

Liver disease? ❑ Yes ❑ No

Venereal disease? ❑ Yes ❑ No

A.I.D.S., or H.I.V. positive? ❑ Yes ❑ No

Epilepsy or Seizures? ❑ Yes ❑ No

Anemia? ❑ Yes ❑ No

Abnormal bleeding from a cut? ❑ Yes ❑ No

Do you have any family history of heart disease or stroke? ❑ Yes ❑ No

If yes, explain ______________________

Do you have or have you had any disease, condition or problem not listed above? ❑ Yes ❑ No

If yes describe ______________________

Are you a smoker? ❑ Yes ❑ No

Do you have any allergic skin reactions to metal jewelry? ❑ Yes ❑ No

Have you ever been told that you require premedication with antibiotics prior to dental treatment? ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

Taking Birth Control Pills? ❑ Yes ❑ No

I authorize Permission to discuss Pre-med with family member or leave messages

Signature ______________________

CONSENT FOR TREATMENT

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner, I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Fussell, Humphreys, Humphreys & Harrell of any changes in my health or medication. The undersigned hereby authorizes Fussell, Humphreys, Humphreys & Harrell to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Fussell, Humphreys, Humphreys & Harrell to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. All diagnostic aids and documentation are the property of the practice. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another healthcare provider.

I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient Signature ______________________ Date ______________

Parent/Guardian Signature ______________________ Date ______________

DENTAL HISTORY

Please answer the following questions accurately to permit us to treat you appropriately based on your particular needs. Your answers are confidential and will be used for our records only.

What is the reason for your visit today? ____________________

Reason for changing dental office? ____________________

Date of your last dental visit __________ Previous Dentist's name ____________________

What was done at your last dental visit? ____________________

When were last xrays taken? ____________________

How often do you have dental examinations? ____________________

How often do you brush? __________ Brush is: [ ] Soft [ ] Medium [ ] Hard

How often do you floss? ____________________

What other oral hygiene aids do you use? ____________________

Are you having any discomfort at this time? [ ] Yes [ ] No

If yes, please describe ____________________

____

Have you ever had any unpleasant experiences associated with previous dentistry? [ ] Yes [ ] No

If yes, please describe ____________________

____

Are you nervous about having dental treatment? [ ] Yes [ ] No

If yes, please describe ____________________

____

Do you have any of the following?

Teeth sensitive to [ ] hot, [ ] cold, [ ] biting, [ ] sweets? [ ] Yes [ ] No

Frequent mouth odors or bad tastes? [ ] Yes [ ] No

Frequent cold sores, blisters, etc. in your mouth? [ ] Yes [ ] No

Swelling or lumps in your mouth? [ ] Yes [ ] No

Gums that [ ] bleed, [ ] are sore, [ ] are swollen? [ ] Yes [ ] No

Loose teeth? [ ] Yes [ ] No

A change in your bite or the way your teeth come together? [ ] Yes [ ] No

Food packing between your teeth? [ ] Yes [ ] No

Clicking or popping in your jaws? [ ] Yes [ ] No

Difficulty in opening or closing your mouth? [ ] Yes [ ] No

Frequent headaches, neck aches or shoulder aches? [ ] Yes [ ] No

Have you ever had any of the following?

Periodontal (gum) treatment? ____________________ [ ] Yes [ ] No

If yes, type of treatment

Orthodontic treatment (braces)? If so, when? [ ] Yes [ ] No

A bite plate or mouthguard made? [ ] Yes [ ] No

Your teeth ground or bite adjusted? [ ] Yes [ ] No

Is there anything else about having dental treatment you would like us to know? [ ] Yes [ ] No

If yes, please describe ____________________

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