Morris & Morris, D.D.S. **7846-C Athens Road** **Stokesdale, NC 27357**

ADULT REGISTRATION FORM **DATE:_________**

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Welcome to our dental office! The following information is necessary for your thorough and safe dental treatment. We would like to spend as much time as possible at your first appointment talking about your dental health, rather than filling out this paperwork. Please fill out all forms before arriving for your appointment. Our office policy requires the following information be completed at your first visit: 1. Filled out Adult Registration Forms, 2. Filled out Health History Forms, 3. Filled out Insurance Forms. Thank you for your help in this important step in your dental care.

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Patient Full Name: Nickname:

Address: City: State: Zip:

Social Security #: Date of Birth:

Home #: Work #: Cell #:

Employer's Name/Company:

Employer's Address: City: State: Zip:

Job: Date Last Worked:

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Spouse Full Name: Nickname:

Social Security #: Date of Birth:

Work #: Cell #:

Employer's Name/Company:

Employer's Address: City: State: Zip:

Job: Date Last Worked:

In case of an emergency, whom should we contact?

Name: Relationship: Phone #:

Whom may we thank for referring you to our office?

Who will pay your bills?

Please complete the back of this page IF you have dental insurance coverage.

PATIENT QUESTIONNAIRE – CONFIDENTIAL

NAME______________________________ BIRTHDATE____________ TODAY'S DATE____________

DENTAL HISTORY

1. Reason for visit:______________________________
2. When was your last dental visit?______________________________
3. How often do you brush your teeth?______________________________
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

YES NO 5. Do your gums bleed while brushing?
YES NO 6. Do your gums bleed when flossing?
YES NO 7. Do you feel pain to any of your teeth when brushing or flossing them?
YES NO 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?
YES NO 9. Have you noticed any loosening of your teeth?
YES NO 10. Does food tend to become caught between your teeth?
YES NO 11. Do you have any sores or lumps in or near your mouth?
12. Have you ever experienced any of the following problems in your jaw?
YES NO a. Clicking?
YES NO b. Pain (joint, ear, side of face)?
YES NO c. Difficulty in opening or closing?
YES NO d. Difficulty in chewing?
YES NO 13. Have you had any head, neck, or jaw injuries?
YES NO 14. Do you have frequent headaches?
YES NO 15. Do you clench or grind your teeth while awake or asleep?
YES NO 16. Do you bite your lips or cheeks frequently?
17. Have you ever had:
YES NO a. Orthodontic treatment (braces)?
YES NO b. Oral surgery?
YES NO c. Gum treatment?
YES NO d. Your teeth ground or the bite adjusted?
YES NO e. Worn a bite plane or other appliance?
YES NO 18. Are you satisfied with the appearance of your teeth? If no, what would you change? ________________

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YES NO 19. Have you ever had an upsetting experience in a dental office? If yes, explain ________________

____

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YES NO 20. Is there anything about having dental treatment that bothers you? If yes, explain ________________

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____

OFFICE USE ONLY

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 that you will be receiving. Thank you for answering the following questions.

<u>Please list your family physician and any medical specialists you see at least once a year:</u>

Name	Address	City	Phone #	Name of Specialty

May we consult with your physician if necessary? **YES** **NO**

(OVER)

MEDICAL HISTORY CONTINUED...

YES NO 1. Are you in good health?
YES NO 2. Have there been any changes in your general health within the past year?
3. Date of your last physical exam: ____________
YES NO 4. Are you now under the care of a physician?
YES NO 5. Have you ever been hospitalized for any surgical operation or serious illness?
Please explain.______________________________

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YES NO 7. Are you taking any medicine(s) including non-prescription medicine?
If yes, what medicine(s) are you taking?

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YES NO 8. Have you had any abnormal bleeding?
YES NO 9. Do you bruise easily?
YES NO 10. Have you ever required a blood transfusion?
YES NO 11. Have you had a recent weight loss? If yes, explain ______________________________
YES NO 12. Do you smoke?
YES NO 13. Do you use smokeless tobacco?
YES NO 14. Do you use alcohol? #drings/week __________
YES NO 15. Do you use cocaine or other drugs?
YES NO 16. Are you wearing contact lenses?

WOMEN ONLY:

YES NO 1. Are you pregnant or think you may be pregnant?
YES NO 2. Are you nursing?
YES NO 3. Are you taking birth control pills?

Are you allergic to or have you had reactions to:

YES NO 1. Local anesthetics like novocaine?
YES NO 2. Penicillin?
YES NO 3. Sulfa drugs?
YES NO 4. Barbiturates, sedatives or sleeping pills?
YES NO 5. Aspirin?
YES NO 6. Iodine?
YES NO 7. Metals or any dental materials?
YES NO 8. Food? ______________________________
YES NO 9. Other antibiotics?______________________________
YES NO 10. Other? ______________________________

Do you have or have you ever had the following:

YES NO 1. Rheumatic heart disease or rheumatic fever
YES NO 2. Scarlet fever?
YES NO 3. Heart defect or heart murmur?
YES NO 4. Heart trouble, heart attack or angina?
YES NO a. Do you have pain in your chest upon exertion?
YES NO b. Are you ever short of breath after mild exercise?
YES NO c. Do your ankles swell?
YES NO d. Do you get short of breath when you lie down?
YES NO e. Do you require extra pillow when you sleep?
YES NO 5. Pacemaker?
YES NO 6. Heart surgery?
YES NO 7. High blood pressure?
YES NO 8. Low blood pressure?
YES NO 9. Hepatitis, jaundice or liver disease?
YES NO 10. Stroke?
YES NO 11. Sinus trouble?
YES NO 12. Lung or breathing problems?
YES NO 13. Asthma?
YES NO 14. Hay fever?
YES NO 15. Hives or skin rash?
YES NO 16. Fainting spells or seizures?
YES NO 17. Diabetes?
YES NO 18. AIDS or HIV infection?
YES NO 19. Thyroid problems?
YES NO 20. Allergies?
YES NO 21. Arthritis or rheumatism?
YES NO 22. Joint replacement or implant?
YES NO 23. Stomach ulcer?
YES NO 24. Kidney trouble?
YES NO 25. Tuberculosis?
YES NO 26. Persistent cough?
YES NO 27. Cough that produces blood?
YES NO 28. Cancer?
YES NO 29. Sexually transmitted diseases?
YES NO 30. Epilepsy?
YES NO 31. Anemia?
YES NO 32. Leukemia?
YES NO 33. Glaucoma?
YES NO 34. Have you undergone current or past osteoporosis therapy? (Examples are: Fosamax, Actonel, Boniva pill form)
YES NO 35. Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)? (Examples are: intravenous Aredia. Zometa)
YES NO 36. Sleep Apnea?
YES NO 37. Other? ______________________________

I certify that the information listed is complete and accurate.

X______________________________ Date______________

(Patient, Parent or Guardian)

Is the patient covered by DENTAL INSURANCE? YES______ NO_______

If yes, please fill out the rest of this page. If no, this form is complete.

DENTAL INSURANCE COMPANY'S NAME:

Address:

Employee's Name: Group #: Policy #:

SIGNATURE ON FILE

_____ I authorize use of this form on all my insurance submissions.
_____ I authorize release of information to all my insurance carriers.
_____ I understand that I am responsible for my bill.
_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
_____ I authorize payment directly to my doctor.
_____ I permit a copy of the authorization to be used in place of the original.

EMPLOYEE NAME: (printed)____

SIGNATURE: ____DATE:___________

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Is the patient covered by another Dental Insurance Company? Yes_____ No _____

If yes, then complete the following. If no, then this page is complete.

SECOND DENTAL INSURANCE COMPANY'S NAME:

Address:

Employee/Subscriber Group No. and/or Group Name:

This coverage is through: Self _____ Spouse _____ Parent ____ Other_____

SIGNATURE ON FILE

_____ I authorize us of this form on all my insurance submissions.
_____ I authorize release of information to all my insurance carriers.
_____ I understand that I am responsible for my bill.
_____ I authorize my doctor to act as my agent in helping my obtain payment from my insurance carriers.
_____ I authorize payment directly to my doctor.
_____ I permit a copy of the authorization to be used in place of the original.

EMPLOYEE NAME: (printed)____

SIGNATURE: ____ **DATE:**__________

Paul Kyler Morris, DDS ~ Trumilla Futch Morris, DDS
7846-C Athens Road Stokesdale, NC 27357

OFFICE PAYMENT AND BROKEN APPOINTMENT POLICY
PLEASE **READ AND SIGN**

Patient's Name: ______________________________________

ALL PAYMENT/COPAY DUE AT TIME OF SERVICE

Patient's with dental insurance: We will be happy to file your insurance for you, but you must furnish us with the correct insurance information, and a copy of your insurance identification card. We will ESTIMATE your percentage of services based on your policy and you are expected to pay your portion when the services are rendered. This can range from a few dollars to 100 percent of the procedure. Remember that most insurance policies have a yearly deductible which must be met. You are responsible for any amount that your insurance does not pay. Our contract is with you, not your insurance carrier.

Patient's with no dental insurance: Payment in full is expected on the day services are rendered.

Payment Options: Cash, Check, Visa/MasterCard, Discover, Citi Health Card (0% up to 12 months if approved). See receptionist for details.

Patient's who fail to pay their bill (in a timely manner): Your account will be charged at a rate of 1.5% MPR (18% APR) and/or a $2.00 billing charge for any balance 30 days or more overdue. We also utilize a collection agency which adds the agency's charges to the account balance. This charge is 25% of the account balance.

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Broken appointments are scheduled appointments that are cancelled without a minimum of 24 hours notice prior to the appointment time. ***Patient's who fail to show up or call will be charged a broken appointment fee.***

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I, the undersigned, have filled out the patient information sheet, read the above information, and I agree to it. I certify that I am the patient, or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even though I may have dental insurance coverage, I am responsible for all payments of services rendered.

Are you prepared to pay in full for services rendered? Yes________ No________
If you are covered by insurance, are you prepared to pay your co-payment in full? Yes________ No________

PREFERRED METHOD OF PAYMENT:

CASH______ CHECK______ VISA/MC_____ CITI HEALTH CARD______

DATE: ____________ SIGNATURE: ______________________________
(Patient or responsible party)

If you have any questions regarding the above information, please discuss with the receptionist before being seen by the doctor.