PATIENT REGISTRATION

Patient Is Policy Holder Responsible Party Preferred Name:					Chart ID:	C		ID:
Responsible Party (if someone other than the patient) First Name:	lle Initial:	Middle In		Last Name:	######################################			First Name:
First Name:	***************************************			Preferred Name:	sponsible Party	er Resp	Policy Holder	Patient Is:
Address: Address 2: City, State, Zip:					ner than the patient) —	someone othe	ible Party (if so	Responsib
City, State, Zip: Home Phone: Work Phone: Soc Sec: Drivers Lie:	dle Initial:	Middle I		Last Name:				First Name:
Hone Phone:	100000000000000000000000000000000000000	,00000000000000000000000000000000000000	######################################	Address 2:	000000000000000000000000000000000000000	***************************************	NOO	Address:
Phone:	***************************************	Pager:		9000000000	**************************************		p:	City, State, Zip:
Birth Date:	100000000000000000000000000000000000000	Ext: Cellular:	E		Work Phone:			
Patient Information Address: City: State / Zip: Pager: City: State / Zip: Ext: Cellular: Sex: Male Female Marital Status: Married Single Divorced Separated Widow Sex: Male Female Age: Soc Sec: Drivers Lic: E-mail: 1 would like to receive correspondences via e-mail. Section 2 Section 3 Employment Full Time Part Time Retired Previous Dentist Emails: Part Time Part Time Retired Previous Dentist Employer ID: Pref. Pharmacy: Emergency Contact # Employer ID: Pref. Pharmacy: Emergency Contact # Primary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date: Secondary Insurance Information Name of Insured: Rem. Deduct: Secondary Insurance Information Name of Insured: Rem. Deduct: Relationship to Insured: Self Spouse Child Rem. Benefits: Rem. Deduct: Relationship to Insured: Self Spouse Child Rem. Benefits: Rem. Deduct: Relationship to Insured: Self Spouse Child Reserved: Secondary Insurance Self Spouse Child Rem. Benefits: Rem. Deduct: Self Spouse Child Rem. Deduct: Self Spouse Chi		Drivers Lic:			Soc Sec:			
Address: State / Zip: Pager:	Holder	Secondary Insurance Policy Hol	older	Primary Insurance Policy H	lder for Patient [a Policy Hold	e Party is also a	Responsible I
City:							nformation —	Patient Info
Home Phone:				Address 2:				Address:
Phone:		Pager:		State / Zip:				City:
Sex: Male Female Marital Status: Married Single Divorced Separated Widow Birth Date: Age: Soc See: Drivers Lie:		Ext: Cellular:	Ez		Work Phone:			
E-mail:	wed	Divorced Separated Widowed	Single	Marital Status: Married		Female	Male	Sex:
Section 2 Employment Full Time		Drivers Lic:		Soc Sec:	Age:			Birth Date:
Employment Full Time		pondences via e-mail.	ke to receive correspo	I would li	*			E-mail:
Status: Student Status: Studen		Section 3			on 2 ————	Section		
Student Status: Full Time	*******************************	***************************************		Retired	Part Time	ime	ment Full Tin	Employme
Medicaid ID:		***************************************			Part Time	ime		
Primary Insurance Information Name of Insured:				tist:		,	I ID:	Medicaid I
Primary Insurance Information Name of Insured: Insured Soc. Sec: Insured Birth Date: Employer: Address: Address: Address: Address 2: City, State, Zip: Rem. Benefits: Rem. Deduct: Rem. Deduct: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:			rrommonenenenenenene	acy:	Pref. Pharma	*	r ID:	Employer II
Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date: Employer: Ins. Company: Address: Address: Address 2: City, State, Zip: City, State, Zip: City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:				lyg:	Pref. Hy		r IĎ:	Carrier II
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 Insured Soc. Sec: Insured Birth Date:						rmation	Insurance Inform	Primary Ins
Insured Soc. Sec: Employer: Address: Address: Address 2: City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Insured Birth Date: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:	Other	Self Spouse Child C	onship to Insured:	Relati			ired:	Name of Insure
Address: Address 2: City, State, Zip: City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Insured Soc. Sec: Insured Birth Date:		tourned & bossesof bossesof				***************************************	Sec:	Insured Soc. Se
Address 2: City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Insured Soc. Sec: Insured Birth Date:			Ins. Company:				oyer:	Employe
City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Insured Soc. Sec: Insured Birth Date:			Address:				ress:	Addres
Rem. Benefits: Secondary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:			Address 2:				ss 2:	Address
Secondary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:			City, State, Zip:				Zip:	City, State, Zi
Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec: Insured Birth Date:			simoniminan	. Deduct:	Rem.		efits:	Rem. Benefit
Insured Soc. Sec: Insured Birth Date:						nformation -	ry Insurance Info	Secondary
Insured Soc. Sec: Insured Birth Date:	Other	Self Spouse Child C	onship to Insured:	Relati			ired:	Name of Insure
		Total Land		Insured Birth Date:			Sec:	Insured Soc. Se
Employer: Ins. Company:			Ins. Company:	Management			oyer:	Employe
Address: Address:			Address:				ress:	Addres
Address 2: Address 2:			Address 2:				ss 2:	Address
City, State, Zip: City, State, Zip:			City, State, Zip:				Zip:	City, State, Zi
Rem. Benefits: Rem. Deduct:			400000000000000000000000000000000000000	. Deduct:	Rem.		efits:	Rem. Benefit

Peachers Mill Dental Medical History

									Ith problems that you may for answering the followin	
Are you under a physicia	an's care now?		Yes €) No		If yes				
Have you ever been hos operation?	pitalized or ha	d a major) No		If yes				
Have you ever had a se	rious head or r	eck injury?	⊕ Yes €) No		If yes				
Are you taking any med	ications, pills,	or drugs?	⊚ Yes €) No		If yes				
Do you take, or have yo	100		Yes			If yes				
Have you ever taken For any other medications of			Yes () No		If yes				
Are you on a special die	t?		⊕ Yes €) No						
Do you use tobacco?			⊕ Yes €) No						
Women: Are you										
Pregnant/Trying to g	et pregnant?		Nursing	? .				Taking or	ral contraceptives?	
Are you allergic to any of t	the following?	THE R. P. LEWIS CO., LANSING, MICH.					COURS .			
Aspirin		Penicillin					Codeine		Acrylic	
Metal		Latex					Sulfa Drugs		Local Anesthetics	
Other?						If yes				
Do you use controlled s	ubstances?		∀es () No		If yes				
Do you have, or have you	had, any of the	e following?								
AIDS/HIV Positive	Yes No	Cortisone M	edicine	(h) Y	es () No	Hemophilia	Yes No	Radiation Treatments	⊚ Yes ⊚
Alzheimer's Disease		Diabetes		⊕ Y	es 🤅) No	Hepatitis A	Yes No	Recent Weight Loss	Yes
Anaphylaxis	Yes No	Drug Addicti	on	(Y	es 🤅) No	Hepatitis B or C	Yes No	Renal Dialysis	⊕ Yes ⊚
Anemia	Yes No	Easily Winde	d	1 Y	es 🛭) No	Herpes	Yes No	Rheumatic Fever	Yes
Angina	Yes No	Emphysema		Y	es 🤅	No	High Blood Pressure	Yes No	Rheumatism	Yes
Arthritis/Gout	🖰 Yes 🖱 No	Epilepsy or 5	Seizures	⊕ Y	es (No	High Cholesterol	Yes No	Scarlet Fever	Yes 💮
Artificial Heart Valve	Yes No	Excessive Bl	eeding	1 Y	es () No	Hives or Rash	Yes No	Shingles	Yes
Artificial Joint	Yes No	Excessive Th	nirst	1 Y	es 🤅) No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes
Asthma	Yes No	Fainting Spel	ls/Dizziness	(Y	es 🤅) No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes
Blood Disease	Yes No	Frequent Co	ugh	(Y	es 🤅) No	Kidney Problems	Yes No	Spina Bifida	Yes
Blood Transfusion	Pyes No	Frequent Dia	arrhea	(ii) Y	es 🤅) No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes
Breathing Problems	Yes No	Frequent He	adaches	@ Y	es 🤅) No	Liver Disease	Yes No	Stroke	PYes
Bruise Easily	Yes No	Genital Herp	es	@ Y	es 🤅) No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes
Cancer	Yes No	Glaucoma		(Y	es () No	Lung Disease	Yes No	Thyroid Disease	Yes
Chemotherapy	Yes No	Hay Fever		∀	es (No	Mitral Valve Prolapse	Yes No	Tonsillitis	P Yes
Chest Pains	Yes No	Heart Attack	/Failure) No	Osteoporosis	Yes No	Tuberculosis	Yes
Cold Sores/Fever Blister:	S Yes No	Heart Murm	ur	(i) Y	es (No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes
Congenital Heart Disorder	Yes No	Heart Pacen	naker	(Y	es @) No	Parathyroid Disease	Yes No	Ulcers	Yes 💮
Convulsions	Yes No	Heart Troub	le/Disease	1 Y	es () No	Psychiatric Care	Yes No	Venereal Disease Yellow Jaundice	Yes Yes
Have you ever had any	carious illnass	not listed	Yes (® No		If yes			Tellow Jauliuice	0 100
ave you ever nou driy	octions illiess	not nated	0 103 (J. 140		Ti Agg				
Comments:										
To the best of my knowle	dge, the quest	ions on this form	have beer	accr	ırate	ly ansv	vered. I understand that	t providing incom	ect information can be dan	gerous to r
patient's) health. It is my	responsibility to	inform the den	tal office of	any	cnan	ges in	medicai status.			
Signature of Patient, Parent	or Guardian:									



Dr. Jeffrey F. Trembley 1502 Tiny Town Road, Suite A Clarksville, Tennessee 37042 (931) 919-9191 (931) 919-4996 Fax www.peachersmilldental.com

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/or attorney fees.

Insurance Statement

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

Disappointment Fee

I understand it is my responsibility to give the doctor at least a 24 hour notice if I am unable to keep my appointment. In the event that I do not give the 24 hour notice or do not call and do not show up, the doctor reserves the right to charge a \$75.00 cancellation fee. This will compensate for the time he/she had reserved to treat me and was unable, due to lack of notice, to schedule another patient for treatment during that time.

Authorization

I hereby authorize and acknowledge that any scanned signature is to be considered an original signature.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received a Notice of Privacy Practices from the office of Peachers Mill Dental.

Signature of Patient or Responsible Party	Date: