# Carolina Dental Specialists

**Orthodontics & Periodontics**
**Dr. R. Bailey, Jr.**

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**Patient Registration** Today's Date: ___/____/____

First Name: _____ MI: _____ Last Name: _____

Nickname: _____ DOB: ___/____/_____ SS#:_____-_____-_____ Sex: M/F

Address: _____ Apt#_____ City: _____

State: _____ Zip code: _____ Phone # (_____) _____-_____ Cell # :(_____)_____-_____

Occupation: _____ Employer: _____

E-mail Address: _____

Emergency Contact: _____ Tel # :(____) _____-_____ Relationship to patient:_____

**Whom may we thank for referring you to our practice?** _____

**How else did you hear about us?** _____

**Responsible Party Information: (If Patient is a Minor, Please Give Parent or Guardian Name)**

Name of Responsible Party: _____ Relationship to Patient: _____

DOB: _____/_____/_____ Home Ph#: (_____)_____- _____ Cell # (_____)_____-_____

Address: _____City:_____State:_____Zip:_____

**Medical Insurance Information: (Please provide your medical insurance card)**

Subscriber Name: _____ DOB: ____/_____/_____ SS#_____-_____-_____

Relationship to patient: _____ Employer: _____

Member ID: _____ Group #:_____ Ins. Tel. #: (_____) _____-_____

***Additional Medical Insurance:***

Subscriber Name: _____ DOB: ____/_____/_____ SS#_____-_____-_____

Relationship to patient: _____ Employer: _____

Member ID: _____ Group #:_____ Ins. Tel. #: (_____) _____-_____

**Dental Insurance Information: (Please provide your dental insurance card)**

Subscriber Name: _____ DOB: ____/_____/_____ SS#_____-_____-_____

Relationship to patient: _____ Employer: _____

Member ID: _____ Group #:_____ Ins. Tel. #: (_____) _____-_____

***Additional Dental Insurance:***

Subscriber Name: _____ DOB: ____/_____/_____ SS#_____-_____-_____

Relationship to patient: _____ Employer: _____

Member ID: _____ Group #:_____ Ins. Tel. #: (_____) _____-_____

**Dental History:**

Name of General Dentist: _____ Address: _____

Date of Last Dental Visit: __/__/___ Date of Last X-rays: ___/____/____

Have you been diagnosed/treated for periodontal disease? ____Yes ____No

Have you had a Scaling & Root Planning? ("Deep Cleaning") ____Yes ____No (If Yes, Date(s): _____/_____/_____)

Have you had a periodontal surgery? ____Yes ____No (If Yes, Date(s) _____/_____/_____)

If yes, explain: _____

Any concerns or issues you would like to bring to our attention? If yes, Please explain: _____

_____

**Medical History:**

Are you under the care of a Physician? ____Yes ___No if yes, please explain: _____

Physician's Name_____ Tel #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Are you pregnant, or suspect that you may be? ____Yes ___No Weeks: _____

Do You Currently use or Have a History of Tobacco Use? ___Yes ___No Form of Tobacco Used: _____

**Are you currently taking any of the following blood thinners?** ___No ___Yes (Check all that apply)

___Coumadin ___Warfarin ___Plavix ___Heparin ___Lovenox ___Aggrenox ___Aspirin

**Are you sensitive or allergic to any of the following?** (Check all that apply)

___Aspirin ___Barbiturates ___Codeine ___Latex ___Amoxicillin ___Sedatives ___Sulfa

___Dental Anesthetics ___Jewelry/Metals ___Erythromycin ___Acetaminophen ___Penicillin

___Tetracycline ___NSAIDs ___Other: _____

**List all medications that you are currently taking:** _____

_____

Preferred Pharmacy Name: _____ Tel #: (_____) _____-_____

Pharmacy Address/Location:_____

**Do you have any of the following conditions? (Check all that apply)**

| | | | |
|---|---|---|---|
| ___ Circulatory problems | ___Pacemaker | ___Heart Attack | |
| ___Heart Murmur | ___Chest pains | ___Artificial Heart Valves | ___ Artificial Joints |
| ___ Back problems | ___ Hypertension | ___Cholesterol | ___ AIDS-HIV |
| ___ Auto Immune Disorder | ___Thyroid problem | ___Kidney Disease | ___Liver Disease |
| ___Diabetes | ___Rheumatic Fever | ___Arthritis | ___Stroke |
| ___ Angina | ___Fainting | ___Epilepsy | ___Cancer |
| ___ Radiation treatment | ___Leukemia | ___Emphysema | ___Tuberculosis |
| ___ Asthma | ___Sinus problems | ___Hay fever/Allergies | ___Ulcer |
| ___Headaches/Migraines | ___ Anemia | ___Hepatitis | ___Anxiety |
| ___Hearing impaired | ___Herpes | ___HPV | ___Mental disorder |
| ___Dementia/Alzheimer's | ___Autism | ___ADD/ADHD | ___Canker sores |
| ___ Bleeding/clotting disorder | | ___Mitral Valve Prolapse | |

If you checked yes to any of these conditions, please explain: _____
_____

I understand payment is due at the time service(s) are rendered. I authorize Carolina Dental Specialists as a courtesy to verify insurance coverage, to submit claims, provide my insurance company(ies) with information required to file claims, to assigned benefits, and handle any appeals. The agreement of the insurance company to pay for your dental care is a contract between you and your insurance company. We know questions can arise on insurance matters. We encourage you to discuss such questions with our business office staff. We will be happy to help you receive the maximum benefit(s). When applicable; we will file with your medical insurance in efforts to reduce your out-of-pocket expense. If coverage is provided, this may result in preserving your dental coverage &/or more money back in your pocket.

**Name (print)** _____**Date**_____**/**_____**/**_____

**Signature**_____
**(If patient is under 18, Parent/Guardian Must signed paperwork)**