A Quality Smile for You

Dr. Tracy Durant

Family and Cosmetic Dentistry

PATIENT REGISTRATION FORM

Today's Date: Patients Chart #:

PATIENT INFORMATION

Patient's Name: _____
First: Middle: Last:

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

Email: _____ Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Sex: ☐ Male ☐ Female Birth Date: ___/___/___ Age: ____ Soc. Sec. #_____-____-_____ Driver's License #: _____

Occupation: _____ Patient Employer: _____ Patient Employer Phone: _____

Patient Employer Address: _____ Student Status: ☐ Full-Time ☐ Part-Time

Spouse or Parent/Guardian's Name: _____ Phone: _____ Employer: _____ Work Phone: _____

How were you referred to us? ☐ Insurance Plan ☐ Family ☐ Friend ☐ Website ☐ Internet ☐ Ad Other _____

Preferred Pharmacy: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of person responsible for this account: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

Email: _____ Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Birth Date: ___/___/___ Age: ____ Soc. Sec. #_____-____-_____ Driver's License #: _____

Employer: _____ Employer Phone: _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Name of Insured: _____ Birth Date: ___/___/___ Soc. Sec. #_____-____-_____

Primary Ins. Company: _____ Ins. Address: _____ Ins. Phone: (___)-____-_____

Policy no.: _____ Group no.: _____ Max. Annual Benefit: _____.00 Rem. Deduct: _____.00

Secondary Ins. Company (if applicable) : _____ Ins. Address: _____

Ins. Phone: (___)-____-_____ Policy no.: _____ Group no.: _____

IN CASE OF EMERGENCY

Emergency Contact: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Home phone no.: (___)-____-_____ Moblie phone no.: (___)-____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Tracy Durant, DDS and A Quality Smile For You. I understand that I am financially responsible for any balance. Dr. Tracy Durant, DDS and A Quality Smile For You may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient/Guardian signature: _____ Date: _____

A Quality Smile For You, P.C.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

A Quality Smile for You

Dr. Tracy Durant

Family and Cosmetic Dentistry

Name: _____ **Date:**_____

Medication Information

Medication Name	Circle One	Dosage	How many times a day?	Reason for taking medication	How long have you been taking?
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
	Brand or Generic				
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	Brand or Generic				
	Brand or Generic				
	Brand or Generic				

W E L C O M E

A Quality Smile For You, P. C.

Dr. Tracy Durant, D.D.S.

1125 N. Anderson Rd., Suite 104

Rock Hill, SC 29730

Phone: 803-325-8178 Fax: 803-325-8179

We would like to take the opportunity and thank you and your family for choosing our office for all of your dental care. Here at A Quality Smile we take much pride in knowing that you have even referred your closest friends and co-workers to our office. It is an honor to know the service we provide will help educate you on some of the latest techniques. **Please take the time to read our office policy prior to coming aboard.**

_____As a patient at A Quality Smile, I agree to honor a **24-hour** cancellation notice of my appointment. I understand my account will access a fee of **$25.00** should I fail to give an ample notice. This fee will apply after your 1st broken appointment that is not confirmed. A fee of **$50.00** will apply to any confirmed broken appointments.

_____I agree to inform the office if I have any x-rays **less than 3** years old or agree to pay for any duplication of x-rays should my insurance company denies payment.

_____I agree to pay a **$35.00** return check fee **(NSF)** to A Quality Smile if the check I write has insufficient funds.

_____I agree to honor **parking limitations** by parking only in the assigned spaces for A Quality Smile. Not in the spaces for Hertz and Speedy Oil.

_____Please understand our waiting area has **limited** seating and for your convenience we ask that you bring **only** those who are schedule for the next visit.

_____I understand that all payment is **due** when services are rendered unless other financial arrangements have been made **prior** to appointment.

_____I understand that if I choose to do a financial agreement for my dental account, I will incur a **$5.00 service fee** to my account for the dental treatment each month until the balance is at zero.

_____I understand that if I call the emergency after-hours phone number **803-4871288** there will be a **$75.00** charge **added** to my account.

Signature: _____ Date: _____
Patient or Parent/Guardian

Employee Signature: _____ Date_____

A Quality Smile for You

Dr. Tracy Durant

Family and Cosmetic Dentistry

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of use and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient or Parent/Guardian

If signed by patient representative, state relationship to patient _____