BARKSDALE DENTISTRY
JOHN BARKSDALE, D.D.S.
family dentist

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:		First name:	Marital Status:	Today's Date:
Is this your legal name? Yes No	If not, what is your legal name?	Date of Birth (DOB): - -	Age:	Sex: M or F
Address:		City:	State:	Zip:

Social Security Number (SSN):	**Please check the best number to reach you at during the day:**		
	☐ Home phone number:	☐ Work phone number:	☐ Cell phone number:
Other family members seen here (if applicable):	Who can we thank for referring you to our office?		Email address:

INSURANCE INFORMATION

(Please present your insurance card to the receptionist.)

Person responsible for account:	Subscriber DOB: - -	Relationship to patient:	Cell phone #:
Is this person a patient here?		Subscriber employer:	Subscriber SSN:
Insurance provider:		Group #:	Member #:

IN CASE OF EMERGENCY PLEASE CONTACT:

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Cell phone #:

DENTAL HISTORY:

Please briefly explain your present dental problems, concerns or desires: ____

____

Please mark your current level of dental pain:

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Please mark your current level of dental anxiety:

0 1 2 3 4 5 6 7 8 9 10

Not anxious — Worst possible anxiety

Have you ever been prescribed antibiotics by a doctor/dentist prior to dental treatment or teeth cleaning? Yes No

Have you ever had a bad dental experience? Yes No If so, please explain:______________________________________

What did you like/dislike about your previous dental office? ____

____

HEALTH HISTORY		
What is the reason for today's visit? How can we help you?	Are you currently under the care of a physician? Whom?	Allergies? (e.g. Penicillin, Epinephrine, metal)
Have you ever taken bisphosphonates (oral or IV) for osteoporosis? (e.g. Boniva, Fosamax, Actonel)	Have you ever had problems with abnormal bleeding?	Have you ever had any complications due to local or general anesthesia?

Have you EVER or CURRENTLY have:

Joint Replacement	Yes	No	Rheumatic heart disease	Yes	No
Heart ailment/ disease	Yes	No	Bacterial Endocarditis	Yes	No
Heart attack	Yes	No	Stroke	Yes	No
Angina	Yes	No	Fainting, Dizziness	Yes	No
Congestive Heart Failure	Yes	No	Shortness of breath	Yes	No
Pacemaker/ Defibrillator	Yes	No	Diabetes	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
High/low blood pressure	Yes	No	Hepatitis	Yes	No
Liver trouble, jaundice	Yes	No	Prostate trouble	Yes	No
Kidney trouble	Yes	No	Osteoporosis	Yes	No
Anemia, Leukemia, Low Platelets	Yes	No	Sleep apnea/ use a CPAP machine	Yes	No
Asthma, Hay Fever	Yes	No	Glaucoma	Yes	No
Autoimmune disease	Yes	No	Psychiatric treatment	Yes	No
Arthritis	Yes	No	Frequent headaches/migraines	Yes	No
Epilepsy, convulsions	Yes	No	Syphilis	Yes	No
Rheumatic Fever	Yes	No	HIV/AIDS	Yes	No
Thyroid trouble	Yes	No	Cancer	Yes	No
Eczema, Hives	Yes	No	Tobacco	Yes	No
Stomach ulcer	Yes	No	GERD	Yes	No

Have you ever been under the care of a physician for any injury or illness not listed above? Please explain.

____

Are you now taking:	**If so, please list drug:**		
Antidepressants	Yes	No	____________________
Drugs for High Blood Pressure	Yes	No	____________________
Drugs for sleep	Yes	No	____________________
Cortisone, Steroids, ACTH	Yes	No	____________________
Blood thinners	Yes	No	____________________
Tranquilizers, Sedatives	Yes	No	____________________
Antibiotics	Yes	No	____________________
Insulin	Yes	No	____________________
Any other prescriptions?	Yes	No	____________________
Any over-the-counter medicines?	Yes	No	____________________
Any herbal medications?	Yes	No	____________________

FEMALES:

Are you currently pregnant? Yes No | Do you plan on being pregnant soon? Yes No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Barksdale Dentistry or insurance company to release any information required to process my claims. I also acknowledge that I have been offered a copy of the office's "Notice of Privacy Practices".

Patient/Guardian signature **Date**

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When you return this form to the receptionist, **please bring your insurance card**. It is important that we always have your **current** and **accurate** insurance information to bill your insurance and *are not responsible* for any unpaid claims due to not having been informed of changes in employment and/or insurance benefits.

As a courtesy to you, we will bill your insurance company for the services provided. **All co-payments and unsatisfied deductibles must be paid at the time of service;** our office expects payment in full from your insurance within 45 days unless otherwise specified by a contract with your insurance provider. In the event that your insurance makes payment at a later date, all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage, including any legal or other cost incurred in the collection of this account should it become delinquent. I authorize Barksdale Dentistry to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to Barksdale Dentistry.

Signed:______________________________ Date:________________

Acknowledgement of Receipt of Privacy Notice
Effective July 1, 2014

I have been presented with a copy of Barksdale Dentistry's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information.

Signed:______________________________ Date:_________________

The person listed below has my permission to discuss my medical information:

Printed Name:_______________________ DOB:________________
List 4 digits of SSN:________________