PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

Date

Name

Spouse

Address

City State Zip

Home Phone

Cell Email

Birthdate Age Male Female

Married Single Divorced Widowed

Social Security Number

School Grade

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Drivers Lic. #

Relationship to Patient SSN

Address

City State Zip

Phone No.

YOU

Name

Occupation

Employer's Name

Address

City State Zip

Phone No.

SPOUSE

Name

Occupation

Employer's Name

Address

City State Zip

Phone No.

DENTAL INSURANCE

Primary Carrier

Insurance Company

Group No.

Employer Name

Insured's Name

Insured's SSN

Date of Birth

Relationship to Patient

Secondary Carrier

Insurance Company

Group No.

Employer Name

Insured's Name

Insured's SSN

Date of Birth

Relationship to Patient

GETTING TO KNOW YOU

Is another member of your family a patient in our office?

Name Relationship

You Were Referred to Us By

Your Former Address

City State Zip

Person to Contact for Emergency

Phone No.

Address

City State Zip

Closest Relative Not Living With You

Phone No.

Address

City State Zip

Are you having pain or discomfort at this time? .....YES NO
Have you been a patient in the hospital during the past two years? .....YES NO
Have you been under the care of a medical doctor during the past two years? .....YES NO

Physician's Name _____

Address _____ Telephone _____
Are you now taking any medication, drugs or pills? .....YES NO

If yes, please list _____
Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .....YES NO

If yes, please list _____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Artificial Joints	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Ulcers	YES	NO	A.I.D.S	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy.	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
Latex Sensitivity	YES	NO						

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .....YES NO
Do your ankles swell during the day? .....YES NO
Do you use more than two pillows to sleep? .....YES NO
Have you lost or gained more than 10 pounds in the past year? .....YES NO
Do you ever wake up from sleep and feel short of breath? .....YES NO
Are you on a special diet? .....YES NO
Has your medical doctor ever said you have a cancer or tumor? .....YES NO
Do you have or have you had any disease, condition, or problem not listed? .....YES NO

If yes, please list _____
WOMEN: Are you pregnant? YES NO If yes, what month?_____ Are you nursing? YES NO Are you taking birth control pills? YES NO

I understand that above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

CONSENT:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in

connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I hereby authorize my insurance company to make payment to Timothy Kornegay, DMD, PLLC.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Reviewed by _____ Date _____