JAMES P. BRENT, DDS 122 East Booneslick Road, Warrenton, MO 63383

PATIENT REGISTRATIONS FORMS

Name: ______________________________ I prefer to be called ______________________

Today's Date ________________ Email Address: ______________________________

Referred by ____

Date of birth _____/_____/_____ Social Security # ____________________ Status: S M W D SEP

Home Address ____
Street City State Zip

Home # ____________________ Cell # __________________ Work # ________________

How and when is the best time to reach you? ____

Employer:__________________________ Occupation: ___________________________
(If child – parents employer)

Employers address ____
Street City State Zip

Emergency Contact

Name: __________________________ Phone #__________________________

Spouse or Parent Information

Name:________________________ Birthdate_____/_____/_____Social Security #______________

Employer:______________________________ Work #______________________

Dental Insurance Information – Please hand card to business assistant

Primary Insurance____

Insured's Name______________________SS#_______________ Date of birth ____________

Insured's Employer____

Secondary Insurance ____

Insured's Name________________________SS#___________ Date of birth ______________

Insured's Employer____

Although dental personnel primary 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 taking the time to answer the following questions.

Yes No Are you under a physician's care now? If yes, please explain:____________________________
Yes No Have you ever been hospitalized or had a major operation? If yes, please explain:________________
Yes No Have you ever had a serious head or neck injury? If yes, please explain:______________________
Yes No Are you taking any medications, pills or drugs? If yes, please list:________________________
Yes No Are you on a special diet?____
Yes No Do you use tobacco?____
Yes No Do you use controlled substances?_______________________________________

For Female Patients: Are you: Pregnant? Yes No If yes due date_________________, Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other: please explain____ (Circle all that applies).

Are you taking any **blood thinners** or **medicine for Osteoporosis**? Yes or No Please list _____________________________
____

Do you have, or have you had, any of the following? (Circle all that applies)

AIDS/HIV Positive	Alzheimer's disease	Anaphylaxis	Angina	Arthritis/ Gout
Artificial Heart Valve	Artificial Joint	Asthma	Blood Disease	Blood Transfusion
Breathing problems	Bruise Easily	Cancer	Chemotherapy	Chest Pains
Cold Sores/fever blisters	Congenital heart disease	Convulsions	Cortisone Medicine	Diabetes
Drug Addiction	Easily Winded	Emphysema	Epilepsy or Seizures	Excessive Bleeding
Excessive Thirst	Fainting spells/dizziness	Frequent cough	Frequent Diarrhea	Frequent Headaches
Genital Herpes	Glaucoma	Hay Fever	Heart Attack/failure	Heart Murmur
Heart Pace Maker	Heart Trouble/Disease	Hemophilia	Hepatitis A	Hepatitis B or C
Herpes	High Blood Pressure	Hives or rash	Hypoglycemia	Irregular Heartbeat
Kidney Problems	Leukemia	Liver Disease	Low Blood Pressure	Lung Disease
Mitral Valve Prolapse	Pain in Jaw Joints	Yellow Jaundice	Psychiatric Care	Radiation Treatments
Recent Weight Loss	Renal Dialysis	Rheumatic Fever	Rheumatism	Scarlet Fever
Shingles	Sinus Trouble	Spinal Bifida	Stroke	Stomach/intestinal disease
Swelling of Limbs	Thyroid Disease	Tonsillitis	Tuberculosis	Tumors or growths
Ulcers	Venereal Disease	Parathyroid disease		

Have you ever had any serious illness not listed above? If yes please explain:_______________________________________
Additional 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.

Consent:
The undersigned hereby authorizes Dr. Brent to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's needs. In addition, it is understood by the undersigned that the use of anesthetic agents in dental procedures embodies a certain risk.

I also authorize Dr. Brent to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) ____.

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. If insurance is involved, as a courtesy, this office accepts direct payment from insurance companies, and will attempt to estimate the patient portion of the visit and that portion will be due at the time of the visit.

Assignment of Benefits: I hereby authorize payment directly to the above-named dentist of the group dental benefits otherwise payable to me. I also understand that this is a contract between myself and the insurance company and I am financially responsible to any charges not covered by insurance.

____ ____________________
Signature of Patient, Parent, or Guardian & Relationship Date

____
Dr. James P. Brent, DDS

Please Note: If unable to complete your appointment, kindly give 24 hours notice. A broken appointment hurts three people, you, another patient who could have had that appointment, and us. For this reason, fees may be accessed on Broken Appointments.