Welcome and thank you for choosing our office.

PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered confidential)

Patient's Last Name_____First _____ MI ____ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ Dr. ☐

I prefer to be called _____

Home Phone _____ Bus. Phone_____ Birth Date_____ Age _____

Mailing Address _____ City _____ Zip _____ How Long?_____

Home Address _____ City _____ State _____ Social Security No._____

Patient's Employer _____ Occupation _____

Spouse _____ Social Security No. _____ Employer _____ Bus. Phone_____

Nearest relative not living with you _____ Phone _____

Has any member of your family been treated in this office? Yes _____ No _____ Who? _____

Whom may we thank for referring you? _____
(Please check one) : Family ☐ Friend ☐ Location ☐ Yellow Pages ☐ Website☐ Other☐ _____

I will be paying today by : Care Credit ☐ Cash ☐ Discover VISA / MC ☐ Check ☐ (in state bank with Drivers License only)

I understand and agree that (regardless of my insurance status) I am responsible for the balance on this account for any professional services rendered through the office of Barry C. Willis, D.D.S. Payment is due and expected at the time of service. If obligations remain unpaid past the date of service, I agree that late payment charges (and collection expenses in the event of default) can be added to the unpaid balance. I authorize this office to obtain information concerning any statements made herein and understand that this may include a credit bureau report. I authorize release of personal health information, including x-rays, for purposes of treatment.

PATIENT SIGNATURE _____ DATE_____

FOR PATIENTS WITH DENTAL INSURANCE

Acceptance of your dental insurance by our office is not a guarantee that your insurance company will pay its co-payment. Your company may pay some, all or none of the insurance estimate. The undersigned party is liable for financial payment and is responsible for the entire treatment fee. If we accept assignment of benefits, you must pay your deductible and co-payment at the time of service. Any remaining balance must be paid by you within 45 days from the initial claim date or within ten days of company settlement, whichever is sooner. Any reimbursement by your company after this date will be refunded to you through our office. I agree that late payment charges and collection expenses in the event of default may be added to the balance. I authorize the release of any information relating to any insurance claim with this office. I authorize payment of the dental benefits otherwise payable to me directly to Barry C. Willis, D.D.S. I permit a copy of this authorization to be used in place of the original.

Insured Employee's Name_____ Social Security No._____

Employer_____ Birth Date_____

Name of Plan_____ Group No. _____

Spouse's Name of Insurance Plan if Applicable? _____Plan No. _____Birth Date_____

HEALTH QUESTIONNAIRE

Please answer each question. Check yes or no where applicable.

MEDICAL HISTORY

FOR OFFICE USE ONLY

Date____/_____/_____
Signature_____

Date____/_____/_____
Signature_____

Date____/_____/_____
Signature_____

1. Are you in good health? ……. ☐ yes ☐ no
2. Date of last physical examination?_____
3. Are you now under the care of a physician?……. ☐ yes ☐ no
   If so, what is the condition being treated?_____
4. Have you ever had any serious illness or operation? ☐ yes ☐ no
5. Have you ever been hospitalized?…… ☐ yes ☐ no
   If so, what was the problem?_____
6. Are you taking any drugs or medicine?……... ☐ yes ☐ no
   If so, what?_____
7. Are you sensitive or allergic to any drugs, metals, etc? ☐ yes ☐ no

   If so, what?_____ ☐ Latex ☐ Nickel ☐ Codeine ☐ Aspirin ☐ Penicillin ☐ Antibiotics
8. Do you have, or have you had any of the following: (check if yes – leave blank if no)

☐ Allergies	☐ Heart Ailments, Murmurs	☐ Respiratory Disease	☐ Fainting Spells
☐ Anemia	☐ Osteoporosis / osteopenia	☐ Fibromyalgia	☐ Chest Pain
☐ Asthma or Hay Fever	☐ Hepatitis, Jaundice or Liver Disease	☐ Sinus Trouble	☐ Thyroid
☐ Blood Diseases	☐ High Blood Pressure	☐ Stroke –When?_____	☐ AIDS/HIV
☐ Cancer	☐ Kidney Disease	☐ Stomach Ulcers	☐ Blood Transfusion
☐ Diabetes	☐ Low Blood Pressure	☐ Tuberculosis	☐ Immune System Disorder
☐ Epilepsy or Seizures	☐ Mental or Nervous Disorders	☐ Tumors or Growths	☐ Frequent Heada
☐ Excessive Bleeding	☐ Head Injuries	☐ Venereal Disease	☐ Drug/Alcohol Problems
☐ Heart Attack_____	☐ Radiation Treatment of any kind	☐ Arthritis	☐ Prosthetic Joints

9. Have you used "bone builder" medicines for osteoporosis? ☐ yes ☐ no (9a.) Do you wear a pacemaker? ☐ yes ☐ no
10. Have you had heart surgery?..... ☐ yes ☐ no (10a.) Do you take blood thinners such as coumadin or plavix ? ☐ yes ☐ no
11. Do you have any diseases, conditions, or problems not listed that we should know about?.....…… ☐ yes ☐ no
    If so, explain_____
12. (Women) Are you pregnant or nursing? ☐ yes ☐ no ? Birth Control Pills/Hormones ? ☐ yes ☐ no

DENTAL HISTORY

Dental complaint at this moment?_____

13. Have you ever had any jaw-joint pain, noise, popping, clicking, or locking? Any history of jaw-joint injury ☐ yes ☐ no
14. Have you ever had any unfavorable reaction from a local anesthetic? (Novocaine, Lidocaine, etc.).....… ☐ yes ☐ no
15. Have you had any serious problems associated with any previous dental treatment?..... ☐ yes ☐ no
    If so, explain _____
16. Does dental treatment make you nervous?…… ☐ yes ☐ no
    If yes, check: ☐ Slight ☐ Moderate ☐ Extremely What in particular?_____
17. How long has it been since you have had dental x-rays of your entire mouth? _____
18. How long since your last dental treatment? _____/_____/_____ Date of last cleaning? _____/_____/_____
19. Have you ever had excessive bleeding after dental treatment that required treatment?.....… ☐ yes ☐ no
20. Do you prefer to maintain healthy teeth and gums? ☐ yes ☐ no ☐ unsure ? 21. Do your gums bleed? ☐ yes ☐ no
22. Have you ever had gum disease or gum surgery? ☐ yes ☐ no 23.Do you like the appearance of your smile? ☐ yes ☐ no

Former Dentist_____ City_____ Phone_____
Name of Physician_____ City _____ Phone_____
Additional Health Information_____

I hereby authorize Dr. Barry C. Willis to perform such dental operations or procedures, and to administer anesthesia, medications, sedatives, and nitrous oxide as may be deemed necessary or advisable in the diagnosis and treatment of the above named patient.

CONSENT FOR TREATMENT:

SIGNATURE_____ Date_____

Authorization must be signed by the patient or by the legal guardian in the case of a minor or when the patient is physically or mentally impaired.

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