REGISTRATION
(PLEASE PRINT)

JACKIE C. BROWN, D.D.S.
9055 Corporate Gardens Drive
Germantown, TN 38138
901-758-1000

Email address _____

Cellular/Pager # _____

Date_____

Home phone _____

PATIENT INFORMATION

Patient name_____
Last First Initial Nickname

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient employed by_____ Occupation_____

Business address_____ Business phone_____

Spouse name _____ Spouse employed by _____

Spouse business address_____ Spouse business phone_____

Your Social Security no._____ Spouse Social Security no. _____

In case of emergency who should be notified?_____ Phone_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Person responsible for account_____
Last First Initial

Relationship to patient_____ Responsible person birthdate_____ SS # _____

Address (if different from patient's)_____ Phone _____

City_____ State_____ Zip_____

Person responsible employed by_____ Occupation_____

Business address_____ Business phone _____

DENTAL INSURANCE (Fill out if necessary)

PRIMARY COVERAGE

Employer _____

Employee name_____

Social Security no._____ Birthdate _____

Name of insurance company_____

Insurance address_____

Group number _____

SECONDARY COVERAGE

Employer _____

Employee name_____

Social Security no._____ Birthdate_____

Name of insurance company_____

Insurance address _____

Group number _____

CONSENT

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, and payable at the time services are rendered unless financial arrangements have been made. I hereby consent this office to obtain any necessary credit information, history or reports needed prior to performing any services or any financial obligation. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (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.

_____ _____
Patient signature (parent if under age 18) Date

_____ _____
Doctor signature Date

DENTAL HEALTH HISTORY

(Confidential)

Today's date_____

Patient name_____ Birthdate _____

DENTAL HISTORY

Reason for today's visit_____

Former dentist_____

Address_____

Date of last dental care_____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Peridontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____ Do you use Nitrous Oxide (laughing gas) ❑ Yes ❑ No

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates_____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have or have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet/Ankles
- ❑ Tobacco Habit
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy name _____

Phone _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbituates (sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other _____

_____

_____

PAYMENT AND SIGNATURE

If you have insurance we request that you pay your estimated portion when services are rendered.
Please indicate the form of payment you wish to choose to settle your account: ❑ Cash or check ❑ Credit card
The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I will inform this office of any changes regarding patient's health status.

Date_____ Signature:_____