J. Lee Pettigrew, D.D.S.

Patient Registration

Welcome to our office! So that we may become better acquainted with you and be better able to serve you please provide us with the following information:

Name: ____________________ ____________

last *first* *middle* *preferred*

Address: ____________________

City: __________ State: __________ Zip: __________

Sex ◯ Female ◯ Male Birthdate: __________ ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Employed by: __________ Home Phone: __________

Cell Phone: __________

Bus Phone: __________

Spouse employed by: __________ Spouse Bus Phone: __________

Hobbies/Interests: ____________________

Children names/ages: ____________________

Emergency contact: __________ Phone: __________

E-mail address: ____________________

Social security #: ____________________

Driver's license#: ____________________

Spouse's social security #: ____________________

Spouse's birthdate: __________

Mail reason for today's visit ____________________

Whom may we thank for referring you to our office? ____________________

J. Lee Pettigrew, D.D.S.

Patient Medical History

Have you had a heart murmur or rheumatic fever? ______________________ ◯ Yes ◯ No
Have you had a heart attack? ______________________________________ ◯ Yes ◯ No
Do you have high or low blood pressure? ______________________________ ◯ Yes ◯ No
Have you had a stroke? ____ ◯ Yes ◯ No
Do you have an implant or implanted medical device (joint, hip, pacemaker, defibrillator) ___________________________________ ◯ Yes ◯ No

What medications and supplements are you taking? (list)

Do you use Tobacco in any form? ____________________________________ ◯ Yes ◯ No
Do you have allergies or asthma? ____________________________________ ◯ Yes ◯ No
Are you allergic to any medication? __________________________________ ◯ Yes ◯ No
Do you have a sleep disorder, apnea, snoring or difficulty sleeping? ______ ◯ Yes ◯ No
Do you have a lung disease (Tuberculosis, COPD, emphysema)? __________ ◯ Yes ◯ No
Do you have problems with your eyes (cataracts, glaucoma)? ____________ ◯ Yes ◯ No
Do you have a kidney problem? _____________________________________ ◯ Yes ◯ No
Do you have a digestive tract disorder (reflux, IBS)? ___________________ ◯ Yes ◯ No
Is there a history of diabetes in your family? ____________________________ ◯ Yes ◯ No
Do you have a blood disorder (anemia, leukemia, hemophilia)? ___________ ◯ Yes ◯ No
Do you have HIV or are you immunocompromised? ____________________ ◯ Yes ◯ No
Have you had seizures or a convulsive disorder? _______________________ ◯ Yes ◯ No
Have you had a tumor or cancer? ____________________________________ ◯ Yes ◯ No
Have you received chemotherapy or radiation therapy? __________________ ◯ Yes ◯ No
Are you pregnant/months? ____ ◯ Yes ◯ No
Are you under the care of a physician? ________________________________ ◯ Yes ◯ No
Have you been hospitalized or had medical treatment in the last 5 years? ◯ Yes ◯ No
Have you had x-rays in the last 2 years? _______________________________ ◯ Yes ◯ No
Do you have stiff muscles or joints? ___________________________________ ◯ Yes ◯ No
Have you had an injury to your face or jaws? ____________________________ ◯ Yes ◯ No
Do you have any disease, problem or condition not listed? _______________ ◯ Yes ◯ No

I certify that the above statements regarding my health are accurate and complete. I realize that omissions may endanger my health or result in less than optimal treatment results.

Signature____ Date

J. Lee Pettigrew, D.D.S.

Patient Dental History

Please describe the reason for your new patient/consultation appointment (include the history of the present condition and symptoms).

Please rate your smile on a scale of 1-10 (10 being best) [ ]

When was your last dental examination? [ ] Cleaning? [ ] Xrays? [ ]

Please share your goals for your oral health [ ]

Do you have any of the following (circle those which apply):

History of orthodontic treatment	◯ Yes	◯ No
Crowded or crooked teeth	◯ Yes	◯ No
Spaces between your teeth	◯ Yes	◯ No
Areas where food packs between your teeth	◯ Yes	◯ No
Loose teeth	◯ Yes	◯ No
Red, swollen or bleeding gums	◯ Yes	◯ No
Sensitive teeth or gums	◯ Yes	◯ No
Gum recession	◯ Yes	◯ No
Past or current instance of gum disease	◯ Yes	◯ No
Discolored or dark teeth	◯ Yes	◯ No
Old unsightly crowns with black lines	◯ Yes	◯ No
Chipped, thin or worn teeth	◯ Yes	◯ No
Clenching or grinding your teeth	◯ Yes	◯ No
TMJ, jaw or facial muscle soreness	◯ Yes	◯ No
Pain in ears, eyes, head or neck	◯ Yes	◯ No
Frequent headaches	◯ Yes	◯ No
Wear a nightguard	◯ Yes	◯ No
Snoring, daytime sleepiness or sleep apnea	◯ Yes	◯ No
Acid reflux (GERD)	◯ Yes	◯ No
Anxiety over dental treatment	◯ Yes	◯ No
Difficulty with past dental treatment	◯ Yes	◯ No

Initials____________________ Date [ ]

J. LEE PETTIGREW D.D.S.

FINANCIAL AND INSURANCE INFORMATION

What person is responsible for this account?

Insured's name

Insured's address

Insured's company | Phone

Mailing address

Group policy #

Secondary ins. company | Phone

Mailing address

Our office is pleased to accept your insurance assignment. We offer this as a courtesy to our patients. However it must be understood that the contract is between you and your insurance company. **You are responsible for any amount that your insurance does not cover**. The following are our policies regarding insurance claims

- You must provide all insurance information forms filled out and signed
- You will pay the estimated percentage of your bill as treatment is rendered
- Your insurance should pay in 30-60 days. If your insurance has not paid within 90 days we may request that you pay the balance due and you be reimbursed by your insurance company
- You will need to notify us of any changes to the above information.

ANY unpaid balance in excess of 90 days may be subject to collection. If this account must be placed in the hands of an attorney or agency for collection, I agree to pay the holder's reasonable fees and collection costs in addition to the outstanding balance.

* Any balance due after 30 days may be assessed a $10.00 office fee per billing cycle.

Your signature below further authorizes us to release all necessary information to secure payment of benefits and authorizes use of this signature on all insurance submissions.

Signature of patient

Date