Bruce M. Scarborough, DMD
306 Highland Boulevard • Natchez, Mississippi 39120

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name Last First MI — Date of Birth

Residence Street City State Zip — Social Security Number

Mailing Address Street City State Zip — Sex ☐ M ☐ F

Home Phone — Work Phone Ext. — Marital Status

Employer Occupation How Long? — Email Address

RESPONSIBLE PARTY INFORMATION *(If other than patient)*

Name Last First MI — Date of Birth

Mailing Address Street City State Zip — Social Security Number

Home Phone — Work Phone Ext. — Relation to Patient

Employer Occupation How Long?

PATIENT OR RESPONSIBLE PARTY'S SPOUSE

Name Last First MI — Relationship

Employer Occupation How Long?

Social Security No. Date of Birth Work Phone Ext.

DENTAL INSURANCE *(Primary Carrier)*

Insured's Name

Insurance Co.

Insurance Co. Address

Group No. Local No.

DENTAL INSURANCE *(Secondary Carrier)*

Insured's Name

Insurance Co.

Insurance Co. Address

Group No. Local No.

X

Signature of Patient or Guardian — Today's Date

Patient Name	**MEDICAL HISTORY**
Date	Medical Alert

1. Have you been under the care of a physician during the past two years? ..... Yes No

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No

   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No

   If yes, please list: .....
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A (infectious) B (serum)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
10. **Women:** Are you: **Pregnant?** Yes, ____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Parent/Guardian Signature X _____ Date X _____

History Review

Dentist Signature _____ Date _____

Patient Name	**DENTAL HISTORY**
Date	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

_____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		
Do you:		
Clinch or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly ?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke, chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		
_____		
Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?		
_____		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		
_____		

Is there anything else about having dental treatment that you would like us to know? Yes No

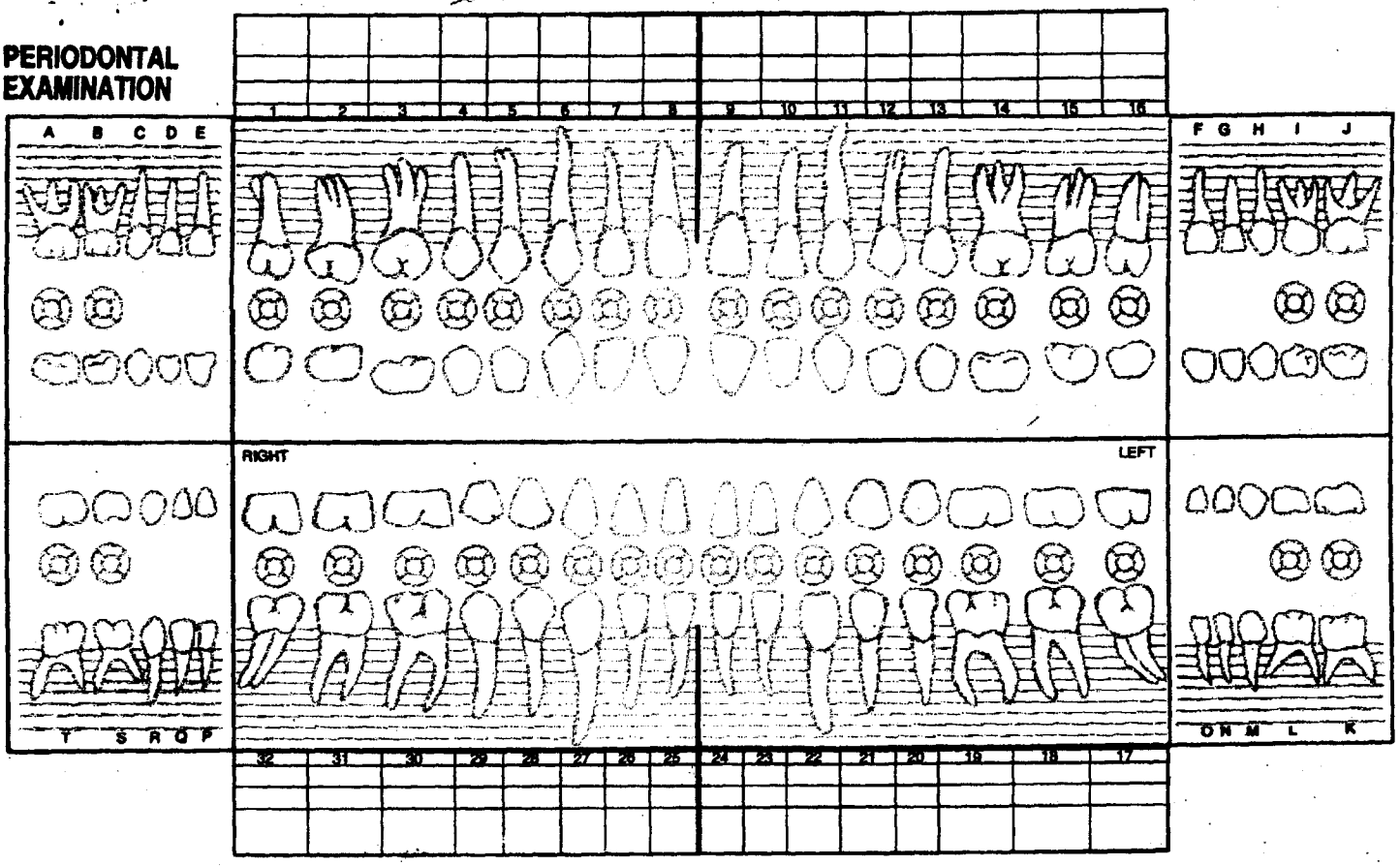
If yes, please describe _____

_____

(Please complete other side)

DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS

PERIODONTAL EXAMINATION



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMATION:	❑ Slight	❑ Moderate	❑ Severe
SOFT PLAQUE BUILDUP:	❑ Slight	❑ Moderate	❑ Heavy
HARD CALC. BUILDUP:	❑ Slight	❑ Moderate	❑ Heavy
STAINS:	❑ Light	❑ Moderate	❑ Heavy
HOME CARE EFFECTIVENESS:	❑ Good	❑ Fair	❑ Poor
PERIODONTAL CONDITION:	❑ Good	❑ Fair	❑ Poor
PERIODONTAL DIAGNOSIS:	❑ Normal	❑ Moderate	❑ Severe
PERIODONTITIS:	❑ Early	❑ Gingivitis	
GINGIVAL INFLAMATION:	❑ Slight	❑ Moderate	❑ Advanced

MUCOGINGIVAL DEFECT #s: _____

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ❑ FM-PAS ❑ BWX ❑ Pano ❑ Other _____

❑ NO BONE LOSS
❑ SLIGHT BONE LOSS (04600)
❑ MODERATE BONE LOSS (04700)
❑ MAJOR BONE LOSS (04800)
❑ BEGINNING FURCATION (04700)
❑ ADVANCED FURCATION (04800)
❑ OTHER: _____

QUADRANTS

UR	UL	LR	LL

CLINICAL DATA

OCCLUSION: ❑ Class I ❑ Class II ❑ Class III ❑ Crossbite _____

T.M.J. EXAM: ❑ Normal ❑ Popping ❑ Deviation ❑ Tooth Wear ❑ Pain

INITIAL SOFT TISSUE EXAM

❑ Lips ❑ Floor of Mouth ❑ Palate
❑ Tongue ❑ Neck & Nodes

NOTES

_____

_____

_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained. In the event this account is turned over for collection, I agree to pay all expenses of collection, including court costs and reasonable attorney fees.

PATIENT Signature (Parent of Child) X _____ Date X _____ DENTIST Signature _____

BRUCE M. SCARBOROUGH, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, X_____, have received a copy of this office's Notice of Privacy Practices.

X_____
{Please Print Name}

X_____
{Signature}

X_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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