Southern Comfort DENTAL
YOUR FAMILY & COSMETIC DENTIST

Patient Registration

If you have any questions, please call us at: (334-491-1725)

Our office is committed to the meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA

Personal Information

Patient Full Name_____ Preferred Name_____ Birth Date_____

SS#_____ Marital Status:___Single___Married___Divorced___Widowed Spouse's Name:_____

Home # ( )_____ Cell Phone # ( ) _____ Work # ( ) _____

Home Address_____ City_____ State_____ Zip_____

Email Address_____ College Student? Yes No If So, Where?_____

Emergency Contact_____ Relationship_____Phone # ( )_____ Referred by_____

Medical Information

1. Are you presently under the care of a physician? Yes No
2. Have you ever had high blood pressure? Yes No
3. Has a physician ever said you have heart trouble? Yes No
4. Do you have Artificial Joints?.....When_____ Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? Yes No
6. Have you ever had an anesthetic (either local or general)? Yes No
7. Has a physician or dentist ever said you have a tumor or cancer? Yes No
8. Are you allergic to Penicillin, Novocain, Codeine or any other medication? Yes No
   If so, What? _____
9. Are you allergic to anything other than medication? (e.g. latex or metals) Yes No
   If so , What? _____

Do you take or have you taken any Bisphosphonates listed (circle):

Fosamax Actonel
Didronel Actonel with Calcuim
Boniva Reclast

Do you have or have ever had:

1. Rheumatic Fever Yes No
2. Heart Disease/Pacemaker Yes No
3. Anemia Yes No
4. Leukemia Yes No
5. Low platelets Yes No
6. Tuberculosis Yes No
7. Diabetes?(circle one) Type 1 Type 2 Yes No
8. Kidney Trouble Yes No
9. Liver Trouble or jaundice Yes No
10. Thyroid trouble or goiter Yes No
11. Syphilis Yes No
12. Fainting or dizziness Yes No
13. Glaucoma Yes No
14. Arthritis Yes No
15. HIV / AIDS Yes No
16. Stroke Yes No
17. Stomach Ulcer Yes No
18. Heart Murmur Yes No
19. Prostate trouble Yes No
20. Hepatitis Yes No
21. Eczema or Hives Yes No
22. Psychiatric treatment Yes No
23. Are you pregnant? How many weeks_____ Yes No

Are you now taking:

1. Drugs for high blood pressure Yes No
2. Drugs for Sleep Yes No
3. Cortisone, Steroids or ACTH Yes No
4. Anticoagulants or blood thinner Yes No
5. Tranquilizers or sedatives Yes No
6. Antibiotics Yes No
7. Insulin Yes No

Have you ever been under the care of a phycisian for any major illness or injury, not listed above? (Please note)_____

_____

Please list treating Medical Doctor that you are currently under their care.

For what? What City/State are they located?_____

_____

_____

Account/Insurance Information

Person Responsible for Account_____ Relationship to Patient_____

Insurance Holder's Name_____ Sex____ DOB_____ SS#_____

Insurance Holder's Employment_____ Insurance Company Name_____

Any #'s that me be required (such as: Member I.D. Group#, ect.)_____

Additional Insurance Coverage:

Person Responsible for Account_____ Relationship to Patient_____

Insurance Holder's Name_____ Sex____ DOB_____ SS#_____

Insurance Holder's Employment_____ Insurance Company Name_____

Any #'s that me be required (such as: Member I.D. Group#, ect.)_____

I verify that the preceding information is true. I authorize the release of information to my insurance company. I authorize release of any information relating to my claim. I authorize payment directly to Southern Comfort Dental. I understand all fees not paid by my insurance company is my responsibility. I will allow the Doctors and Staff of Southern Comfort to discuss my conditions with my physician(s) and to request medical information from them. I authorize the office of Southern Comfort Dental to obtain and verify a credit report, if credit is extended to my account. I also acknowledge that I have been given or offered a copy of the of office's "Notice of Privacy Practices."

Signature_____ Date_____