Jeffery W. Hadley, D.D.S.

Registration Information

Please Print

Today's Date: _____

About You

Patient: _____
Last Name First Name Middle Initial

Mailing Address: _____
Street City State Zip Code

Home Number: _____ Work Number: _____ Social Security #: _____

Cell Number: _____ E-mail Address: _____

Sex: M [] F [] Age: _____ Birthdate: _____ Single [] Married [] Widowed [] Separated [] Divorced []

Responsible Party

Name: _____ Contact Number: _____

Address: _____
Street City State Zip Code

Insurance

Primary Cardholder

Insurance Company: _____

Subscriber's Name: _____ DOB: _____

ID/SSN: _____ Group # _____

Employed By: _____

Secondary Cardholder

Insurance Company: _____

Subscriber's Name: _____ DOB: _____

ID/SSN: _____ Group # _____

Employed By: _____

I prefer to: [] Pay my balance in full at time of service.
[] Make payment arrangements prior to services being rendered.

In case of emergency who should be notified? _____ Contact Number: _____

Your Drugstore Name: _____ Phone Number: _____

How did you learn of our office? _____

Mutual Goals

The mouth is our means of eating, speaking and showing emotion. It is also a major factor in our general appearance. In the diseased state it can cause generalized poor health, pain, infection and even personality changes. Most people want to be comfortable, attractive, able to chew well, and keep their own teeth all of their lives. All of these things are possible in this office, but it takes careful planning. Therefore we try to establish mutual long range dental goals and begin working toward them.

Appointment Time

Extended, well planned appointments usually mean fewer trips to the office resulting in less time lost from work or school. We are able to accomplish more treatment in less time and at no additional cost. It is very important that you understand that this is **time set aside especially for you** and that appointments should be made only at times when they can definitely be kept with your best interest in mind. Patients should also understand **we have prepaid our care team to be in place for your appointment. If you are unable to cancel your appointment within 24 hours so we may fill your reservation, a cancellation fee will apply.** Appointments will be scheduled at times best suited for the treatment involved.

Health History

1. Initial concern/reason for office visit:_____
2. Date of last Dental exam and cleaning:_____
3. Have you been under the care of a medical doctor during the past two years? Explain:_____

Physician's Name:_____Phone #:_____

4. Have you taken any recreational drugs within the past two years? (Marijuana, Cocaine, etc.)..... Yes No
5. Are you now taking any medication, drugs or pills?..... Yes No

If yes, please list:_____

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance..... Yes No

If yes, please list:_____

7. Indicate which of the following you have had or have at present. Circle "Yes" or "No" each item:

A.I.D.S.....	Yes	No	Epilepsy or Seizures.....	Yes	No	Mitral Valve Prolapse.....	Yes	No
Allergies or Hives.....	Yes	No	Heart Disease or Attack.....	Yes	No	Orthodontic Treatment.....	Yes	No
Angina Pectoris.....	Yes	No	Heart Failure.....	Yes	No	Pain in Jaw Joints.....	Yes	No
Arthritis.....	Yes	No	Heart Murmur.....	Yes	No	Periodontal Treatment.....	Yes	No
Artificial Heart Valve.....	Yes	No	Heart Pacemaker.....	Yes	No	Rheumatic Fever.....	Yes	No
Artificial Joints (Hip, Knee)...	Yes	No	Heart Surgery.....	Yes	No	Scarlet Fever.....	Yes	No
Asthma.....	Yes	No	Hepatitis A (infectious).....	Yes	No	Sinus Trouble.....	Yes	No
Blood Disorder.....	Yes	No	Hepatitis B (Serum).....	Yes	No	Sleeping Disorders.....	Yes	No
Blood Transfusion.....	Yes	No	Hepatitis C.....	Yes	No	Stroke.....	Yes	No
Cortisone Medicine.....	Yes	No	High Blood Pressure.....	Yes	No	Thyroid Disease.....	Yes	No
Cosmetic Surgery.....	Yes	No	HIV Positive.....	Yes	No	Tuberculosis (TB).....	Yes	No
Diabetes.....	Yes	No	Kidney Trouble.....	Yes	No	Ulcers.....	Yes	No
Drug Addiction/Abuse.....	Yes	No	Latex Allergy.....	Yes	No	Venereal Disease		
Emphysema.....	Yes	No	Liver Disease.....	Yes	No	(Syphilis, Gonorrhea).....	Yes	No

8. Do you expect to lose your teeth?..... Yes No
9. Are you dissatisfied with your smile?..... Yes No
10. Anything about dental treatment that bothers you?..... Yes No

Comments:_____

11. Are you on a special diet?..... Yes No
12. Do you have any disease, condition, or problem not listed?..... Yes No

If yes, explain:_____

For Women Only:

Are you pregnant? No [] Yes [] If Yes, what month?_____.

Are you taking birth control pills?..... Yes No

Consent:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a billing charge may be added to any balance over 60 days. I also understand that **Non-Sufficient funds fees or No show fees may apply** under the appropriate circumstances. In the event of default I (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_____Date_____Witness_____

Parent or Responsible Party _____ Relationship to Patient