John T. Madison DDS

Marcus Brian Ward DMD

PATIENT REGISTRATION PACKET

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____ Sex: ___ Male ___ Female

Patient Is:

- ☐ Responsible Party
- ☐ Policy Holder

BIRTHDATE: _____

➢ **Patient Information (Confidential)**

Address (Mailing): _____
City, State, & Zip: _____
Home Phone: _____
Cell Phone: _____Text Messages? __Yes / __ No E-mail Address: _____
Work Phone: _____
Driver's License #: _____ (State)_____ Social Security #: _____
Employer: _____
Employer Address: _____
Marital Status:
___ Single ___ Married ___ Separated ___ Divorced ___ Widowed **~ Spouse's Name: _____**

Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact #: _____
PREFERRED PHARMACY: _____ Location: _____

How did you hear about us? ___ Direct Mail Advertisement
___ Website / Social Media
___ Doctor Referral
___ Friend / Family Referred. Who? _____

➢ **Responsible Party (If someone other than patient)**

First Name: _____ Middle Initial: _____ Last Name: _____
Address (Mailing): _____
City, State, & Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Social Security #: _____ Birthdate: _____
Employer: _____ Employer Address: _____

➢ **Dental Insurance Information (Please Present Card)**

Name of POLICY HOLDER: _____ Relationship to Patient: _____
Policy Holders SS#: _____ Policy Holders Birthdate: _____
Insurance Company: _____ Member ID#: _____
Circle One: Employer Provider Policy - OR- Self Pay Policy Employer: _____

➢ **Secondary Insurance Information**

Name of POLICY HOLDER: _____ Relationship to Patient: _____
Policy Holders SS#: _____ Policy Holders Birthdate: _____
Insurance Company: _____ Member ID#: _____
Circle One: Employer Provider Policy - OR- Self Pay Policy Employer: _____

Although the dental profession primarily treats the areas in and around the mouth, your mouth is a part of the entire body. Health problems or medications you take can greatly influence the decisions that will be made pertaining to your care. Please answer the following questions fully and honestly, to the best of your knowledge. Thank you- Dr. John T. Madison

- Are you under a physician's care now? ___ Yes ___ No
  ~ Physicians Name _____ ~Last Exam Date: _____
- Have you ever been hospitalized or had a major operation? ___ Yes ___ No
  ~ If yes, please explain: _____
- Have you ever had a serious head or neck injury? ___ Yes ___ No
  ~ If yes, please explain: _____
- Are you taking **ANY** medications? ___ Yes ___ No ***Do you take ANY Blood Thinners? _____**
  ~ Please list all prescription and non-prescription medications (please print): _____

_____

- Have you **EVER** taken **FOSAMAX, BONIVA, ACTONEL** or **ANY** other medication containing **BISPHOSPHANATES**? ___ Yes ___ No
- Do you use tobacco products? ___ Yes ___ No

WOMEN: Are you...

- Pregnant / Trying to get Pregnant? ___ Yes ___ No
- Taking Oral Contraceptives? ___ Yes ___ No
- Nursing? ___ Yes ___ No

Are you **allergic** to any of the following medications?
___ ASPRIN ___ PENICILLIN ___ CODIENE ___ LOCAL ANESTETICS
___ ARCYRLIC ___ METAL ___ LATEX ___ SULFA DRUGS
___ OTHERS, if yes, please list: _____

Do you have, or have you had, any of the following?

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve
  ~ When: _____
- ☐ Artificial Joint
  ~ When: _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer: _____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes: Type I, Type II
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Pacemaker
- ☐ Heart Trouble
- ☐ Heart Disease
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Stomach Disease
- ☐ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Tumors or Growths
- ☐ Venereal Disease
- ☐ Other:_____

Patient Dental History:

Previous Dentist and Location: _____ Date of Last Exam: _____

- ✧ Do your gums bleed while brushing? ___ Yes ___ No
- ✧ Are your teeth sensitive to hot or cold food / liquids? ___ Yes ___ No
- ✧ Are your teeth sensitive to sweet or sour foods? Liquids? ___ Yes ___ No
- ✧ Do you feel pain with any of your teeth? ___ Yes ___ No
- ✧ Do you have any sores or tumors in or near your mouth? ___ Yes ___ No
- ✧ Have you had any head, neck, or jaw injuries? ___ Yes ___ No
- ✧ Have you ever had any of the following problems in your jaw? ___ Yes ___ No
  - ___ Clicking
  - ___ Pain (joint, ear, side of face)
  - ___ Difficulty in opening or closing
  - ___ Difficulty in chewing
- ✧ Do you have frequent headaches? ___ Yes ___ No
- ✧ Do you clench or grind your teeth? ___ Yes ___ No
- ✧ Do you bite your lips or checks frequently? ___ Yes ___ No
- ✧ Have you ever had any difficult extractions in the past? ___ Yes ___ No- If yes, when? _____
- ✧ Have you ever had prolonged / excessive bleeding after an extraction? ___ Yes ___ No
- ✧ Have you had any Orthodontic treatment? ___ Yes ___ No
- ✧ Do you wear dentures or partials? ___ Yes ___ No- If yes, date of placement: _____
- ✧ Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ___ Yes ___ No
- ✧ Do you like your smile? ___ Yes ___ No

Authorization and Release: (Sign and Date)

I certify that I have read and understand the above information, and have answered all questions accurately and completely to the best of my knowledge. I understand that providing incorrect information can be dangerous and hazardous to my health and dental care. I authorize the office of Dr. Madison & Ward to release any information including the diagnosis, and records of any treatment or examinations rendered to myself or my child during the period of such dental care to third party payer's and / or health practitioners. I authorize and direct my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or guardian Date

Patient Acknowledgment of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed
PLEASE PRINT
and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that the office of John Madison DDS & Marcus Brian Ward DMD will call regarding appointment confirmations and leave a message with DETAILS of appointment time and date using any contact number listed by patient.
(No other information will be shared regarding appointment on any message left).
If you DO NOT want messages left regarding appointments please let the office know how you prefer to be contacted. By signing below you acknowledge and understand the policy regarding appointment confirmations.

I also understand that if I have any questions or complaints, I may contact:

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

For Office use Only

We made a good faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) _____.
- ☐ Communications barriers prohibited obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgement.
- ☐ Other: _____

Attempt was made by : _____

John T. Madison DDS, PA
Marcus Brain Ward DMD
301 S. Willis Dr., Suite 100 Shallotte, NC 28470
PHONE: (910)754-7700 **- FAX (910)754-7077**

Appointment Policies:

- **Confirming your appointment:** Our office will contact you prior to your scheduled appointment as a reminder and confirm your appointment time & date. We will contact you via Home and/or Cell Phone, text messaging, and Email. Please respond or reply to ***confirm all scheduled appointments*** using one of these methods.

I also understand that the office of Dr. John Madison will call regarding appointment confirmations and leave a message with DETAILS of appointment time and date using any contact number listed by patient.

(No other information will be shared regarding appointment on any message left).

If you DO NOT want messages left regarding appointments please let the office know how you prefer to be contacted. By signing below you acknowledge and understand the policy regarding appointment confirmations.

- **Timeliness:** Please make every effort to arrive at your appointment at least five minutes before the scheduled time. This helps our office to keep our schedule on time and to begin your treatments at the scheduled time.
    - It is very important that you keep your scheduled appointment. If for any reason you are unable to keep your appointment- we ask that you notify our office a minimum of 24 hours in advance.

Failure to Keep Your Scheduled Appointment, without 24 hours notice, May Result in Immediate Dismissal from This Practice.

FINANCIAL RESPONCIBILTY

I agree to pay and guarantee payment in full of any and all charges for service provided by John T. Madison DDS, PA at the time of service.

I authorize payment of dental insurance benefits to John T. Madison DDS, PA and understand that BILLING OF INSURANCE IS A SERVICE ONLY, AND NOT A GUARANTEE OF PAYMENT. I understand that any unpaid balance is the responsibility of the patient and must be paid upon receipt of statement, if balance is not paid, the account will be sent to a COLLECTIONS COMPANY and additional interest charges may be added to the remaining balance.

I verify that I have read, understand, and agree to all of the above policies

Signature: _____ Date: _____

Name (Print): _____