



*Distinctive Dentistry for Adults  
Dr. James E. Wright, Jr.*

**Patient Registration Form**  
(Please Print)

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
DOB \_\_\_\_\_ SSN# \_\_\_\_\_ Marital Status (please circle one) M S D W  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Contact Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Responsible Party (if patient is under 21) \_\_\_\_\_  
How Did you hear about Premier Dental Health ? \_\_\_\_\_

**Primary Insurance**

Policy Holder's Name \_\_\_\_\_  
SSN# \_\_\_\_\_ ID# \_\_\_\_\_  
DOB \_\_\_\_\_ Marital Status: M S D W  
Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group Name and Number \_\_\_\_\_

- Thank you for choosing Premier Dental Health LLC. We are excited about the opportunity of helping you achieve optimum dental health through preventative, restorative, and cosmetic treatment. Our commitment is for your treatment to be successful and it is important that you have a clear understanding of all treatment and cost.
- We are not a participating provider for any insurance company. We file with all carriers and most dental policies allow their clients to go to the dentist of their choice.
- As a courtesy to our patients, we gladly file your insurance for you. Our office will assist you in any way to facilitate benefits from your insurance company, but you are responsible for any incurred charges. At the time of treatment we ask that you pay any portion your insurance will not cover.
- Our office accepts Visa, MC, Discover and Cash/Check. We strive to use all available financial options to help you obtain quality dental treatment. Our office uses ResubmittIt, if in the event your check is dishonored or returned, you authorize us to electronically re-present the check to your bank account for collection of the amount of the check, plus any fees permitted by state law.
- Thank you for taking time to read our Financial Policy and Notice of Privacy Practices. Please always feel free to ask any questions you may have. We are here to help you.

I have read and understand our Notice of Privacy Practices and Financial Policy.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

*Premier Dental Health LLC.  
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864.655.7430 864.655.7433 fax premierdentalhealthllc@gmail.com*

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- 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, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  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?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

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

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker          | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments  | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss    | <input type="radio"/> Yes <input type="radio"/> No |                            |  |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_