REGISTRATION / HISTORY

Date ______________________

Patient's Name ____
First Middle Initial Last

Call Name ______________________

Street Address ______________________ Home Phone Number ______________________

City ______________ State ________ Zip ________ E-Mail Address ______________________

Social Security Number ______________________ Birthdate ______________________

Driver's License Number ______________________

Patient Employed by ______________________ Phone ______________________

Business Address ______________________

Present Position ______________________ How long held ______________________

Purpose of this appointment ______________________

In case of Emergency, who should be notified ______________________ Phone ______________________

Who will pay this account ______________________

Single ______

Widowed ______

Married ______

Divorced ______

Separated ______

Name of Spouse ______________________

Spouse's Social Security Number ______________________ Birthdate ______________________

Driver's License Number ______________________

Spouse Employed by ______________________ Phone ______________________

Business Address ______________________

Present Position ______________________ How long held ______________________

Do you have dental insurance that may cover any part of our professional services .... Yes ________ No ________

If so, name of primary company ______________________ Policy No ______________________

Social Security No. of Policy Holder ______________________

Do you have any other dental insurance .... Yes ________ No ________

If so, name of secondary company ______________________ Policy No ______________________

Social Security No. of Policy Holder ______________________

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you ______________________

Comments: ______________________

____

Please complete reverse side

Date of last health care examination ________________________ Current age ________

For what ____

Have you been hospitalized in last 5 years ________ If so, for what ________________________

____

Do you have or have you ever had:

	Yes	No
Aids	___	___
Anemia	___	___
Asthma	___	___
Diabetes	___	___
Epilepsy	___	___
Hepatitis	___	___
HIV positive	___	___
Joint replacement	___	___
Rheumatic fever	___	___
Heart Murmur	___	___
Abnormal heart condition	___	___
Abnormal bleeding from a cut	___	___

Do you need to be pre-medicated before dental work? ________

	Yes	No
Abnormal Blood Pressure	___	___
S___/D___/___		
Are you allergic to:		
Penicillin	___	___
Local anesthetic	___	___
Medication or Drugs	___	___
Women: Are you pregnant	___	___

If allergic to medications or drugs, indicate which ones ________________________________

Are you taking any medication now ________ If so, for what ________________________

Other physical conditions we should be aware of ________________________________

____

Name of your physician ________________________________ Phone ________________

Are you receiving care now ________ If so, nature of care ________________________

Are you now receiving other health care Yes ☐ No ☐

If so, nature of care	Name of doctor	Phone

May we request your health records Yes ☐ No ☐

To whom should we address request ________________________________

____

This information was given by ________________________________

I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT FOR ALL PRESENT AND/OR FORMER FAMILY MEMBERS.

Payments are due and payable at Kellum Dental Clinic, P.A.'s (hereinafter, "Kellum"), place of business in Tupelo, Mississippi and Debtor submits to the jurisdiction and venue of the state courts of Lee County, Mississippi for enforcement of this contract/payment of this account. If this bill is referred for collection, Debtor agrees to pay Kellum an additional 33 1/3% of the original bill (including interest, $150.00 minimum) as attorney fees, plus all costs of collection to include court costs. As part of the consideration for the extension of credit, Debtor hereby waives any exemptions, as to Kellum, allowed by federal (to include bankruptcy) or state law as to execution by Kellum on property or assets of the Debtor or surety for satisfaction for this debt. Debtor agrees to pay interest on all overdue bills at the rate of 1.75% per month (21% annual percentage rate) or such other lesser amount as is allowed by the laws of Mississippi.

SIGNATURE ________________________________

DATE ________________________________