JOSEY LANE
DENTISTRY

2440 North Josey Lane, Suite 102
Carrollton, Texas 75006
PHONE : 972-242-1592 | FAX : 972-245-5905
www.joseylanedentistry.com

Patient Registration

Please complete all blanks. Place N/A if question is not applicable. Date ______

Patient Information

Legal Name ______ Preferred Name ______
Home Address ______ Home Phone ______
City, State, Zip ______ e-mail ______
Employer ______ Work Phone ______
Occupation ______ Pager/Cell Phone ______
SSN# ______
DOB ______ Legal Guardian (if under 18) ______
Male ______ Female ______
Married ____ Single ____ Divorced ____ Widowed ____
List any other family members that are patients ______
How did you hear about us? ______

Insured Party Information

Legal Name ______ Preferred Name ______
Home Address ______ Home Phone ______
City, State, Zip ______ e-mail ______
Employer ______ Work Phone ______
Pager/Cell Phone ______
SSN# ______
DOB ______
Male ______ Female ______

Primary Insurance Company

Please have your card available for our records at every visit.
Company ______ Group # ______
Policy # ______ Insurance Phone ______
Address ______
______
______

What is your immediate dental concern? ______
How long since your last visit? ______

Medical & Dental History

Personal Physician (name, phone, last visit) ______

List any and all medications you are currently taking ______

______

List any and all allergies (drug and material) ______

______

Emergency Contact ______ Phone ______

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

______

Do any of the following conditions apply to you:

Condition			Condition		
Heart Disease	YES	NO	Tuberculosis (date diagnosed)	YES	NO
Heart Surgery (date)	YES	NO	Respiratory Problems	YES	NO
Heart Attack (date)	YES	NO	asthma?	YES	NO
Stroke (date)	YES	NO	COPD?	YES	NO
High or Low Blood Pressure	YES	NO	Cancer (date diagnosed)	YES	NO
Congestive heart failure	YES	NO	chemotherapy? radiation ?	YES	NO
Heart Murmur	YES	NO	Artificial joint(s) (date placed)	YES	NO
Mitral Valve Prolapse	YES	NO	what joint(s)?	YES	NO
Blood Disease	YES	NO	Osteoporosis	YES	NO
Blood Transfusion (date)	YES	NO	Thyroid problems	YES	NO
Hepatitis A, B, C	YES	NO	Autoimmune disorders	YES	NO
Diabetes Type 1 / Type 2	YES	NO	HIV Positive, AIDS	YES	NO
Fainting Spells, Seizures	YES	NO	Currently Pregnant	YES	NO
Severe Headaches	YES	NO	Planning Pregnancy in the future	YES	NO
Alzheimer's Disease / Dementia	YES	NO	Use of tobacco products:	YES	NO
Memory Impairment	YES	NO	what type: cigarettes, e-cigarettes, smokeless tobacco ("dip")		

Are you taking blood thinners for bleeding/clotting problems? ______

ANY OTHER MEDICAL PROBLEMS/CONDITIONS NOT LISTED ABOVE: ______

______

Have you had:

An unhappy or problem dental experience?	YES	NO
Any orthodontic (braces) or periodontal (gum) treatment before?	YES	NO

Have you noticed:

Bleeding Gums	YES	NO
Pain or soreness in either jaw joint?	YES	NO
Popping, clicking or grating in either jaw joint?	YES	NO
Chronic or tension headaches related to your teeth or bite?	YES	NO

______ ______ ______

Signature Printed Name Date

Acknowledgment of Receipt of Notice of Privacy Practices

* you may refuse to sign this Acknowledgment *

I, ____, have read and/or received a copy of this office's Notice of Privacy Practices. The Notice of Privacy Practices is posted within the front office for review or copies available upon request.

____
Please Print Name

____
Signature

____
Date

The office of Josey Lane Dentistry has my permission to discuss my information with the following individuals:

Name	Relationship
Name	Relationship
Name	Relationship

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because;

Individual refused to sign

Communications barriers prohibited obtaining the Acknowledgment

An emergency situation prevented us from obtaining Acknowledgment

Other (Please Specify) ____

Broken Appointment / No Show Policy

The Josey Lane Dentistry team takes pride in our warm, caring atmosphere. One aspect we really value about our practice is the opportunity to provide quality dental care and individual attention to each and every one of our patients.

We strive to see our patients on time, although on occasion some circumstances prevent us from doing so. We respect your time and value your patronage!

When an appointment is missed or canceled without a 48-hour advance notice, it interferes with our capability to treat other patients in need. For this, we request a 48-hour cancellation notice if for any reason you need to change an appointment. By respecting this policy, you will avoid the $50 cancellation fee.

Please understand time with the doctor or hygienist has been assigned to you. If an appointment is repeatedly rescheduled we will need to take a deposit to hold the next appointment spot.

Yours Truly for Optimal Health,

Melissa Scaggs, DDS
Lindsay Penchan, DDS

____ ____________________

Patient Signature Date