Welcome to DentureCare!

Thank you for coming into DentureCare and Implant Solutions! Please take a few minutes to fill out the following pages. If you have any questions please contact one of our receptionists at 252-977-7197.

We look forward to serving you to the best of our ability!

Sincerely,

Dr. Edward Jernigan
Dr. John Carroll Jernigan

Patient Registration

Name* _____ Today's Date _____

Mailing Address*

_____

City* _____ State* _____ Zip Code*_____

Home Phone _____ Work Phone_____

Cell Phone _____

Sex (Please circle): Male Female Married Divorced Single Widow

Date of Birth _____ Social Security Number _____

Driver's License Number _____

Email Address_____

*Denotes Required Field

(Please circle methods by which you prefer to be contracted)

Phone Email Postage Mail

Employer's name _____

Emergency Contact Name and Phone Number _____

Medical Doctor's name and Phone Number _____

General Dentist's name and Phone Number _____

When & Where was your last full mouth x-ray? _____

Preferred Pharmacy name and Phone Number _____

Dental Insurance Information (Please print)

Do you currently have dental insurance? Please select below

- ❑ Yes
- ❑ No

Note: **We DO NOT accept dental insurance as payment. However, we will gladly print the forms for you so you can be reimbursed from your insurance company for any payment they cover. Please give us your insurance card and picture ID when you turn in this form.**

Name of dental insurance company (if yes above)

_____

Is your dental insurance offered to you from your employer?

- ❑ Yes
- ❑ No

Are you currently covered on someone else's dental insurance?

- ❑ Yes
- ❑ No

Is yes, please enter the applicable information for the dental insurance policy you are enrolled in:

- ❑ Name of policy holder _____
- ❑ Policy holder date of birth _____
- ❑ Policy holder social security number _____

Patient Background Information (Please print)

Please briefly explain why you are here for a visit today:

_____
_____
_____
_____

Do you currently wear a denture or partial denture?

- ❑ Yes
- ❑ No

If you answered yes, how old is your current denture or partial? _____

Are you interested in hearing more about dental implants?

- ❑ Yes
- ❑ No

How did you hear about DentureCare and Implant Solutions?

- ❑ Television
- ❑ Yellow Pages
- ❑ Newspaper (If yes which newspaper? _____)
- ❑ Direct mailing
- ❑ Online (website or online advertisement)
- ❑ Social Media (Facebook)
- ❑ Friend/Relative (if so please include name of who referred you below)

  _____
- ❑ Other doctor (if so please include the name of the doctor)

Please list an emergency contact name and phone number in case of emergency:

Emergency Contact Name: _____
Emergency Contact Phone Number:_____
Relation to Patient: _____

Frequently Asked Questions

- Here at DentureCare and Implant Solutions, while we are general dentists, we do not practice the full gamut of general practice of dentistry. If you have any remaining natural

teeth that you wish to maintain and keep for as long as possible, we highly recommend you finding a good general dental practice that evaluates, treats, and maintains each tooth and the gum around those teeth as we do not provide those services.

- Will my contact information be shared with any third parties?
    - No. We will not share your contact information with any third party vendors. We may occasionally reach out to patients through email, telephone, or postage in order to share promotional offers or other applicable information as it pertains to dental services. Text messaging may be also used in order to contact a patient.

- What forms of payment does DentureCare accept?
    - Payment for your visit till be due in full at the time of the visit. Please note that if you choose to pay with a check or credit card, that the account holder should be present at time of payment.
    - We accept the following forms of payment:
        - Cash
        - Check
        - Credit Card (Visa, MasterCard, Discover, and debit cards)
        - Financing companies (please contact receptionist at 252-977-7197 for more details with regards to financing companies)
        - Medicaid
        - We do not accept insurance. However, we will gladly provide you with the needed paperwork in order to be reimbursed by your insurance company.

Dr. Jernigan & Associates. PA

1427 N: Wesleyan Blvd.

Rocky Mount, NC 27804

List all medications, including prescriptions and over the counter, vitamins and/or supplements below:

Medication Name	Dosage	Taken how often	Taken for what condition

List of any allergies that you have to medications or materials and what reaction you had:

Medication	Reaction

☐ No Known Allergies to Medications

Signature of Patient_____

Date_____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X Date:_____