"A Different Level of Care"

BigRiver DENTAL

103 Christian Dr., Ste B
Brandon, MS 39042
601-825-1172

88 Main St West
Meadville, MS 39653
601-384-1684

WWW.BIGRIVERDENTAL.COM

PATIENT REGISTRATION

Please Print All Information

PATIENT INFORMATION

Name: _____

Address: _____

_____

Email: _____

Cell Phone: _____ Extra Phone: _____

Date of Birth: _____ Gender: Male Female

Social Security Number: _____

Drivers License Number: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Phone Number: _____

INSURANCE INFORMATION

Insurance Company: _____

Member ID: _____

Group Number: _____

Name of Insured: _____

Social Security Number of Insured: _____

Date of Birth for Insured: _____

Employer of Insured: _____

Relationship of Insured to Patient: Self Spouse Child Other

PATIENT MEDICAL INFOMATION

Physician's Name: _____

Physicians Location: _____ Phone Number: _____

Hospitalizations, Major Operations, Joint Replacements: _____

Do you use tobacco? Yes No Do you use controlled substances? Yes No

CONSENT AND SIGNATURE

I acknowledge that I have received and/or read a copy of the Big River Dental Notice of Privacy Practices.
I assign Big River Dental benefits, if any, otherwise payable to me for service(s) rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Big River Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
I understand that there may be certain routine services that Big River Dental feels are necessary for the maintenance of good oral health which are not covered by insurance. You will be responsible to pay for all services not covered.
I have read these policies and, by my signature, agree to pay for services not covered by my insurance as well as any legal and/or collection fees necessary for the collection of debt.
ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Patient Signature _____ Date: _____

PLEASE CIRCLE IF YOU HAVE OR HAVE YOU HAVE EVER HAD ANY OF THE FOLLOWING				
AIDS/HIV Positive	Chest Pains	Genital Herpes	Hives or Rash	Renal Dialysis
Anaphylaxis	Cold Sores/Fever Blisters	Glaucoma	Irregular Heartbeat	Rheumatic Fever
Anemia	Congenital Heart Disorder	Heart Attack/Falure	Kidney Problems	Rheumatism
Angina	Diabetes	Heart Murmur	Leukemia	Scarlet Fever
Arthritis/Gout	Drug Addiction	Heart Pacemaker	Liver Disease	Sickle Cell Disease
Artificial Heart Valve	Emphysema	Heart Trouble/Disease	Lung Disease	Stomach/ Intestinal Disease
Asthma	Epilepsy/Seizures	Hemophilia	Mitral Valve Prolapse	Stroke
Blood Disease/ Blood Transfusion	Excessive Bleeding	Hepatitis A	Osteoporosis	Swelling of Limbs
Bruise Easily	Fainting Spells/Dizziness	Hepatitis B	Pain in Jaw Joints	Thyroid Disease
Cancer	Frequent Cough	Hepatitis C	Psychiatric Care	Tubuculosis
Chemotherapy	Frequent Headaches	High Blood Pressure	Radiation Treatments	Tumors/Growths

PLEASE CIRCLE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:							
Asprin	Penicillin	Codeine	Acrylic	Metal	Latex	Local Anesthetics	Sulfa Drugs
Nuts	Antibiotics	Other					

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING	

Patient Signature _____ Date: _____