

**Godley Station Dental Excellence  
Matthew J. Allen, D.D.S.  
E. Tait Carpenter, D.M.D.  
1000 Towne Center Blvd Suite 101  
Pooler, GA 31322  
(912)748-8585**

**Patient Registration**

**Patient Information**

Patient Name: _____		Preferred Name: _____	
Address, City, State, & Zipcode: _____ _____			
Home Phone: _____		Work Phone: _____	
Ext: _____		Cellular: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female    Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Birth Date: _____		Age: _____	
Social Security: _____		Driver's License: _____	
E-mail: _____		<input type="checkbox"/> I would like to receive correspondence via e-mail.	

**Primary Insurance Information**

Name of Insured: _____		Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insured Social Security: _____		Insured Date of Birth: _____	
Employer: _____		Insurance Company: _____	
Address: _____		Address: _____	
City, State, Zipcode: _____		City, State, Zipcode: _____	

**Authorization for the Release of Identifying Health Information**

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:	
Patient/Responsible Party Signature: _____	
Relationship to patient: _____	

**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 \_\_\_\_\_

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**Financial Arrangements**

**Optional Payment Terms:**

1. **Full Pay Cash Discount:** We offer a 5% accounting courtesy for all treatment over \$500 that is paid in full prior to the commencement of treatment.
2. **Full Pay Credit:** We accept full or partial payment by Visa, MasterCard, American Express, or Discover.
3. **Term Loan:** By arrangement with Care Credit, we can offer our patients, upon approval, an interest-free loan (*up to 12 months*) with no down payment, no annual fee, and no prepayment penalty. Ask for an application.

There will be a fee for any additional procedure(s) NOT included in the original treatment plan.

**Payment Policies**

To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. We accept cash, check, check cards, and all major credit cards. Any treatment estimated above \$300.00 must be accompanied by a specific financial arrangement.

**Dental Insurance**

We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage or payment. Because the insurance policy is *an agreement between you and your insurance company*, we ask that all *patients be responsible directly for all charges*. Please know we will do everything possible to see that you receive the full benefits of your policy.

I understand that if my account has been turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of thirty five percent (35%), pursuant to Georgia Statutory Law "O.C.G.A.-13-1-148."

**Patients are responsible for the full amount of their bill.**

**Broken Appointments**

Your appointment is time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours to avoid a cancellation fee.

I, \_\_\_\_\_, understand and agree to the above financial policy.

Patient's or Responsible Party

Party's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Financial Officer: \_\_\_\_\_ Date: \_\_\_\_\_

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Your comfort is our priority. We provide a variety of services to assure that you are comfortable at all times. Please select from the following menu items if you prefer any of these options.

- Patients find that if they take an analgesic prior to treatment, it helps later in the day.  
Which do you prefer?  Tylenol  Advil  Other \_\_\_\_\_
  - We provide various levels of sedation. Would you benefit from a sedative?  
 Yes  No  
If yes, we provide: Nitrous Oxide (*laughing gas*)  
Mild sedative (*Valium, Ativan*)  
Moderate sedative (*Triazolam*)
  - The wand is today's most comfortable numbing technology and we use it routinely. Used in combination with a topical medication from the dermatology profession, The Wand allows you to get numb feeling virtually nothing. Would you like the wand during treatment?  Yes  No
  - Our rooms are equipped with cable televisions. Watching TV is an excellent way to pass the time during your visit. Would you like to watch TV?  
 Yes  No
  - Blankets help keep you warm and relaxed through your visit. Would you like a blanket?  Yes  No
  - A courtesy telephone is always available to you. Please let us know if you need to make a call and we will provide you with assistance.
  - Is there anything else we can do to make you visits as comfortable as possible?
- 
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Our office is very unique and unlike any dental office you have ever been to. Your upcoming visit is an important first step toward getting the dentistry you seek. We place a high emphasis on helping you determine your present as well as your future dental needs, wants, and desires. Here are some things we are going to be talking about at your first visit. These are some issues you may not have considered before. Please answer these questions in a way that best expresses how you feel. Your answers will help us to prepare for your visit so that we may better serve you.

1. Are you having any areas of concern? \_\_\_\_\_
2. What do you think is the current state of your mouth's health? \_\_\_\_\_
3. How do you want us to get your mouth? (*Check one*):  
 Pain relief/repairs only     Average     The best it can be
4. Tell us about your good dental experiences \_\_\_\_\_  
And the bad ones \_\_\_\_\_
5. Why did you leave your last dental office? \_\_\_\_\_
6. What about your smile would you like to improve? \_\_\_\_\_
7. What would it take for you to trust us to be your dentist? \_\_\_\_\_
8. Do you have any family or friends that already come to our office?     Yes     No
9. What do you already know about our office and what are your expectations? \_\_\_\_\_
10. Has fear ever been an issue for you in a dental office?     Yes     No
11. Has time ever been an issue for you in getting your dental work done?     Yes     No
12. Has the cost of dental treatment been a concern for you?     Yes     No If yes, what can we  
Do to help with this? \_\_\_\_\_
13. We have the unique ability to look at your mouth from three different perspectives. Which of these  
would you like us to you for you? (*Please check all that apply*)  
 As a general dentist     As a cosmetic dentist     As a functional dentist
14. At what point do you want to us to initiate treatment? (*please check one*)  
 When my tooth hurts or breaks     When something is worsening     When it's not ideal
15. What quality of dentistry do you want us to recommend?     Repairs     Average     Ideal/the best
16. What additional information would you like us to know? \_\_\_\_\_
17. Your Name \_\_\_\_\_
18. How did you find out about our office? (*please check all that apply*):  
 Personal referral from \_\_\_\_\_     Mail flyer     Newspaper  
 TV     Internet     L.V.I. ad     Other \_\_\_\_\_
19. If you found us on the internet, what search words did you us? \_\_\_\_\_