New Patients

1. Your new patient registration forms need to be completed prior to your dental appointment. The forms can be downloaded from our web site at www.rexpayne.com if it was not mailed to you.

2. Please provide us with your dental insurance information prior to your appointment.

3. Bring your dental insurance card and present it to the receptionist upon arrival. If you do not have a dental insurance card, please let us know.

4. Important – please bring any current dental x-rays to assist us with your dental treatment. You will need to pick up your x-rays or have them mailed to us from your previous Dentist.

5. Please call our office (972) 221-9136 prior to your appointment to verify we have received all necessary information and your dental insurance has been confirmed.

6. If you will be more than 10 minutes late for your appointment, please call our office to verify that your appointment can still be accommodated.

7. Office services, Co-Pays or Deductibles are payable at the time of services. Payment can be made by Visa, MasterCard, Discover, American Express, cash or check.

We are looking forward to meeting you and helping you with your dental needs. Thank You.

Rex Alan Payne, D.D.S.
Lewisville Dental Associates, P.L.L.C.

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Rex Alan Payne, D.D.S.
105 Kathryn Dr. Suite A   Lewisville Tx   75067   (972) 221-9136
PATIENT REGISTRATION

Patient Name:____ Date:___________
First MI Last (Preferred Name)

Address:____
Street Apartment number

____ Employer:________________________
City State Zip Code

Birth Date ____________ Driver License # _________________ SS.# __________________

Hm. Ph __________________ Wk.__________________X______Cell#_________________

Male or Female <please circle> Single / Married / Divorced / Child

If Patient is a Child Parent's Information

Parent's Name ________________________________ Employer ______________________________

Parent work #_________________________________ cell # ______________________________

Spouse Information:

Name________________________________Employer:______________________________

Work # ______________________________Cell # _________________________________

Family member not living with you Name ___________________________Ph#:___________

Insurance Information

Name of Insured:____
Last First MI

Insured's Birth Date:_______________SS / ID #: ____________________Group #:________________

Insured's Employer Name:______________________________ Ph.#______________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____________________

Name of Insurance Company: ____

Insurance Co. Phone Number ____

Who referred you to our office? Name ____
(or) Phone Book ____________ (or) Internet __________

Please check those that apply:

- ☐ **Allergic to:** ____________________ ____________________
- ☐ **Codeine/Vicodin Allergy**
- ☐ **Penicillin Allergy**
- ☐ **Latex Allergies**
- ☐ **Excessive Bleeding**
- ☐ **If Blood Thinners List Below:** ____________________

- ☐ Cancer/Tumors
- ☐ Radiation Treatment
- ☐ Diabetes
- ☐ Fainting
- ☐ Head Injuries
- ☐ Mental Disorders
- ☐ Dizziness
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Disease

- ☐ Blood Disease
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Herpes /Mouth
- ☐ Pregnant
  Due date: ___________
- ☐ Asthma

- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ **AIDS**
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ **PRE-MED**
- ☐ **Heart Murmur**
- ☐ **Mitral Valve Prolapse**
- ☐ **Artificial Joints**
- ☐ **Rheumatic Fever**

*****Other problems not listed____

____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________Ph#_______________ City ____________________
- I am currently taking the following medications:____

____

Are you allergic to any medication or other products not listed above? If so, please list:______________________

____

*Your visit here today is for:*____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. As a courtesy, this office will help file the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable fees accrue hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Patient is responsible for an unpaid balance not paid by your insurance.

All deductibles and co-pays are due at time of appointment.

If unable to keep Appointment Kindly Give us a 24 Hours Notice. Penalties May Apply.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________

Signature of patient, parent or guardian

Doctors / Staff Notes

Date___________ **Date**___________ **Date**___________ **Date**____________ **Date**____________ **Date**_________