REGISTRATION FORM HISTORY

Date _____

Patient Information

Name:_____ Date of Birth _____Social Security # _____

Home phone # ( ) _____ Cell Phone # ( ) _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Driver's License #_____State_____ Email Address:_____@_____

Head of Household Information or Responsible Party

Name _____ Date of Birth _____Social Security # _____

Home phone # ( ) _____ Cell Phone # ( ) _____

Address _____ Apt. # _____ City/ _____ State _____ Zip _____

Driver's License #_____State_____ Email Address:_____@_____

Insurance Information

Name of Insured: _____ Date of Birth:_____Social Security # _____

Employer's Name _____ Employer's Phone: ( )_____

Name of **Primary** Insurance Co. _____ Insurance Co. Phone # ( )_____

Name of **Secondary** Insurance Co. _____ Insurance Co. Phone # ( )_____

Who was your previous dentist? _____

How or whom referred you to our dental office? _____

Are you interested in orthodontics (braces)? ☐YES ☐No

List all medications you are currently taking and their purpose: _____

Are you currently under a physician's care? If so, please give reason:_____

This information I have given is true and correct. I authorize release of any information relating To my dental treatment to any and all insurance carriers that may pay benefits for claims submitted for my dental treatment including those whom I am responsible for. _____ Signed (Responsible Party/Patient, or parent if minor) Date	I hereby authorize payment from my insurance carrier of the dental benefits otherwise payable to me directly to (name of practice) I understand that I am responsible for all cost of dental treatment whether or not my insurance pays for my or whom I am responsible for. _____ _____ Signed (insured person) Date

MEDICAL HISTORY

NAME_____Physician's name_____Phone number_____

Circle any of the following that apply.

1. Are you having pain or discomfort at this time? YES NO
2. Do you feel very nervous about having dentistry treatment? YES NO
3. Have you ever had a bad experience in the dental office? YES NO
4. Have you been a patient in a hospital during the past two years? YES NO
5. Have you been under the care of a medical doctor during the past two years? YES NO
6. Have you taken any medicine or drugs during the past two years? YES NO
7. Are you allergic to (1l.e.., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? YES NO
8. Have you ever had any excessive bleeding requiring special treatments? YES NO
9. Have you ever taken diet medication? Which medication did you use_____ YES NO
10. Do your have Osteoporosis or have you taken the following Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid or Zometa (these are drugs used to treat osteoporosis. They can cause major problems for extractions) YES NO

Please circle **y** for yes for any of the following which you have had or have at the present. Circle **n** for no if you have never had this condition or disease. Please circle one or the other for each condition or disease

y n Heart failure	y n Emphysema	y n Hepatitis A (infectious)	y n Fainting or Dizzy Spells
y n Heart attack (MI)	y n Cough	y n Hepatitis B (serum)	y n Nervousness
y n Angina Pectoris	y n Tuberculosis (TB)	y n Hepatitis C	y n Psychiatric Treatment
y n High Blood Pressure	y n Asthma	y n Liver Disease	y n Stroke
y n Heart Murmur	y n Hay Fever	y n Yellow Jaundice	y n Ulcers
y n Rheumatic Fever	y n Sinus Trouble	y n Liver Transplant	y n Glaucoma
y n Scarlet Fever	y n Allergies or Hives	y n Drug or Alcohol Abuse	y n Bruise Easily
y n Artificial Heart Valve	y n Diabetes	y n Hemophia	y n Pain in Jaw Joints (TMJ)
y n Mitral Valve Prolapse	y n Thyroid Disease	y n Venereal Disease (Syphilis, Gonorrhea)	
y n Heart Pacemaker	y n X-ray Treatment	y n Genital Herpes	y n Arthritis
y n Heart Surgery	y n Kidney Trouble	y n Cold Sores	y n Artificial Joint
y n Anemia	y n Sickle Cell Disease	y n Cortisone Medicine	y n Rheumatism
y n Congenital Heart Lesions		y n Chemotherapy (Cancer, Leukemia)	y n Blood Transfusion

Do you smoke? YES NO Do you use recreational drugs? YES NO

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
12. Do your ankles swell during the day? YES NO
13. You use more than 2 pillows to sleep? YES NO
14. Have you lost or gained more than 10 pounds in the past year? YES NO
15. Do you ever wake up from sleep short of breath? YES NO
16. Are you on a special diet? YES NO
17. Has your medical doctor ever said you have a cancer or tumor? YES NO
18. Do you have any disease, condition or problem not listed? YES NO
19. Women: Are you pregnant now? YES NO Are you practicing birth control? YES NO
    Do you anticipate becoming pregnant? YES NO

CURRENT MEDICATIONS_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. In case you need extensive dentistry requiring a series of payments, we reserve the right to request a credit report to guide us in extending credit.

Because of HIPAA , Federal regulations protecting your privacy, we wish to inform you we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to get paid for our services. You can have access to your records by simply asking. We will give you a copy, if you desire. There is a copy fee. If you feel we have released information you have the right to file a complaint. The above statement is required by Federal HIPAA regulations.

Date_____ Signature of Patient, Parent or Guardian_____All patients BP____/_____

Yearly up dates - If any changes, please tell staff what the changes are.

Date_____ Any changes YES NO Signature _____BP____/_____ ASA I II III IV

Date_____ Any changes YES NO Signature _____BP____/_____ ASA I II III IV

Date_____ Any changes YES NO Signature _____BP____/_____ ASA I II III IV

(the section in bold is to help the dental office be in compliance with HIPAA regulations. You have a right to have a copy of your chart and records. The dentist is allowed to charge for copying the record. They can release information to your insurance company to get paid for the work they have done. They cannot release this information to anyone else. You have the right to complain if they should do this.)