

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

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PHONE NUMBERS

Home _____ Work _____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

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DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth? Yes No

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose teeth or broken filings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw Pain or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lip or cheek biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often do you floss?		
			How often do you brush?		

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding abnormally, with extraction or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No			

WOMEN: Are you: Pregnant? Yes, _____ Months No Nursing? Yes No Taking birth control pills? Yes No**MEDICATIONS**

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

- Aspirin Penicillin
 Barbiturates (Sleeping pills) Sulfa
 Codeine Other _____
 Iodine
 Latex
 Local Anesthetic

X

SIGNATURE OF PATIENT OR PARENT OF MINOR

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UPDATES (To be filled in at future appointments)Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

HIPAA Compliance Patient Consent Form

Our Notice of privacy providers information about how we may use or disclose protected health information. The notice contains a patient's rights section describing you rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations, we are not required to agree with this restriction, but if we do ,we shall honor this agreement . The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this form , you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing , signed by you. However , such a revocation will not be retroactive.

By signing this form , I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent .

May we phone,email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with any member of your family ? YES NO

If YES, please name the members allowed :

This consent was signed by:_____

Signature:_____ Date:_____