PATIENT REGISTRATION FORM

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Email:			Today's Date:	
Name: ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐Dr.	Last	First		Middle
Address:		City:	State:	Zip:
Home Phone: include area code ( )	Cell Phone: include area code ( )	Date of Birth:	SSN:	Sex: M F
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				
Employer:		Business Phone: include area code ( )		
Spouses Name:		Date of Birth:	SSN:	
Spouses Employer:		Spouses Business Phone: include area code ( )		
Emergency Contact:	Relationship:	Home Phone: include area code ( )	Cell Phone: include area code ( )	
May we send text messages & postcards to confirm appointments?		May we leave a message on your answering machine?		
Pref. Pharmacy:	Phone: ( )			
Hobbies / Interests / Travel:				

DENTAL INSURANCE INFORMATION

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse

Insured Soc. Sec.: _____ Insured Birth Date: _____

Ins. Company: _____ Address: _____

City, State, Zip: _____ ID#: _____

Gr#: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse

Insured Soc. Sec.: _____ Insured Birth Date: _____

Ins. Company: _____ Address: _____

City, State, Zip: _____ ID#: _____

Gr#: _____

HIPPA ACKNOWLEDGMENT

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- Bad breath ☐
- Blisters on lips or mouth ☐
- Burning sensation on tongue ☐
- Chew on one side of mouth ☐
- Cigarette, pipe, or cigar smoking ☐
- Smokeless tobacco ☐
- Dry mouth ☐
- Food collection between teeth ☐
- Clench teeth ☐
- Grind teeth ☐
- Growths or sore spots in mouth ☐
- Snores or wakes up frequently at night ☐
- Gums swollen, tender, or bleeding ☐
- Head, neck, or jaw pain or aches ☐
- Lip or cheek biting ☐
- Loose teeth or broken fillings ☐
- Mouth breathing ☐
- Orthodontic treatment ☐
- Nitrous Oxide ☐
- Periodontal treatment ☐
- Sensitivity to pressure or irritants (cold, heat, sweets) ☐
- How often do you floss? _____
- How often do you brush? _____
- Have you ever had an allergic reactions to Novocaine, local or general anesthetics? ☐
  If Yes, please explain: _____
- Have you had trouble from previous dental care? ☐
  If Yes, please explain what happened: _____ _____
- Have you ever bleached or whitened your teeth? ☐

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

- Allergies, hay fever, sinusitis ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Asthma: Required Hospitalization ☐
- Asthma: Used Steroids ☐
- Bleeding abnormally with operation/surgery ☐
- Blood Disease, Clotting Disorders ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Cortisone Treatments ☐
- Cough, persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis? ☐
  Type: _____
- Herpes ☐
- High Blood Pressure ☐
- Any Immune Deficiency (incl. HIV/AIDS) ☐
- Jaundice ☐
- Kidney Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Osteopenia ☐
- Osteoporosis ☐
- Pacemaker ☐
- Radiation Treatments ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Sickle Cell Anemia ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or Growth on Head/Neck ☐
- Ulcer ☐
- Venereal Disease ☐
- Weight Loss, Unexplained ☐
- Do you wear contact lenses? ☐
- Do you consume alcoholic beverages? ☐
- Are you currently under the care of a Physician? ☐
- Are you allergic/sensitive to Latex? ☐
- Allergic to penicillin, Aspirin or Other Drugs? ☐
  If Yes, please specify: _____ _____
- Are you currently taking any Medications? ☐
  If Yes, please list: _____ _____ _____ _____ _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

DENTAL & MEDICAL HEALTH HISTORY