Patient Registration

Date: ______________________

First Name: ____________________________________ Last Name: ____________________________________

Please Circle:
Married Single Child Other Gender: Male Female Title: Mr. Mrs. Ms. Dr. Miss

Date of Birth: ____ Social Security: ________________________________

Driver's License Number: _______________________________ Occupation: __________________________________

Home Address: ________________________________ Work Address: __________________________________

____ ____

Home Phone: __________________________________ Work Phone: ___________________________________

Cell Phone: ___________________________________ Other Phone: __________________________________

Email Address: ____

Emergency Contact Name: ______________________________ Relationship to Patient: _________________________

Emergency Contact Phone: ______________________________ Emergency Contact Alt Phone: ____________________

Person Responsible for Account: __________________________ Relationship to Patient: _________________________

Primary Insurance Carrier Name: ____

Policy Holder Name: _____________________________ Policy Holder Date of Birth: _______________________

Policy Holder ID Number: _________________________ Relationship to Patient: ___________________________

Policy Number: _________________________________

Secondary Insurance Carrier Name: ____

Policy Holder Name: _____________________________ Policy Holder Date of Birth: _______________________

Policy Holder ID Number: _________________________ Relationship to Patient: ___________________________

Policy Number: _________________________________

Pharmacy Name: _______________________________________ Pharmacy Phone Number: ________________________

Primary Medical Physician: ____

Specialists Physician (Cardiologist, Endocrinologist): ____

How did you hear about us? ____

Updated 2/2017

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**: I authorize ____________________________________ (healthcare provider) to use and disclose the protected health information described below to ___________________________ (individual seeking the information).

2. **Effective Period**: This authorization for release of information covers the period of healthcare from:
   a. ☐ __________________ to __________________
   OR
   b. ☐ all past, present, and future periods.

3. **Extent of Authorization**:
   a. ☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   OR
   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental Health Records
      ☐ Communicable Diseases (including HIV and AIDS)
      ☐ Alcohol/Drug Abuse Treatment
      ☐ Other (please specify): _____________________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ______________________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, as any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____
Signature of patient or personal representative

____ _______________________
Printed name of patient or personal representative and his or her relationship to patient

____
Date

Health History Form

Patient's Name (Print) ______________________________________ Date of Birth _____/_________/___________

Gender: Male / Female

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Condition			Condition		
Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? *If yes, please specify:* ____________________________	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? *If yes, please specify:* ____________________________	Yes	No
Artificial joints placed anywhere in the body (heart valve, pacemaker, hip, knee)? *If yes, please specify:* ____________________	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Glaucoma?	Yes	No
Thyroid disease?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Stomach ulcers or colitis?	Yes	No	Diabetes?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Arthritis?	Yes	No
Do you clench or grind your teeth?	Yes	No	Significant weight loss or gain?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Mental Health Issues	Yes	No	Sinus or nasal problems?	Yes	No
Seizures or Neurological Issues	Yes	No	HIV/AIDS	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	HPV	Yes	No
Do you smoke?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Drug or Alcohol Issues	Yes	No			

Any disease, chemotherapy or transplant operation? Cancer? Yes No If so, where? ____,
and when was the date of your last treatment? ____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

When was your last physical examination? ____

Are you under the care of a physician? Yes No Reason:____

Have you had any surgery in the past three (3) years? Yes No Reason:____

Have you been hospitalized in the past twelve (12) months? Yes No Reason:____

Women Only: Is there a possibility you are pregnant? Yes No Are you taking birth control pills or hormonal replacement? Yes No

Are you nursing? Yes No

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No	Penicillin or other antibiotics?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No	Local Anesthesia or Epinephrine?	Yes	No
Sedatives, barbiturates?	Yes	No	Metals	Yes	No			

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? ________________________ Relationship? ________________________

Other drug allergies not listed above: ____

____

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Antianxiety agents, sedative-hypnotics and antidepressants	Yes	No
Prescription pain medication?	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? *If yes, list drugs used and time of use*. ____	Yes	No

Have you been told you need to **premedicate** or take antibiotics before a dental procedure? Yes No

Please list any **other medications** you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: ____

____

____

DOCTOR'S NOTES:

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No *If Yes, please explain?* ____________________________________

When was your last dental visit? ____

What was the reason for your last visit? ____

Do you wear dentures or partials?	Yes	No	Do you like your smile?	Yes	No
Have you ever had periodontal (gum) treatment?	Yes	No	Have you ever been treated for sleep apnea?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No	Do you have any of your x-rays or dental records?	Yes	No

Do you wish to talk to the doctor **privately** about anything? Yes No

How can we help you today? ____

Are you completing this form for another person? Yes No If yes, what is your relationship to the patient: _____________________

I have reviewed and understand the information on this questionnaire and certify that the information I have provided is accurate and complete. I understand that this information will be used by my dental office to help determine the appropriate and healthful dental treatment. If there are any changes in my medical status or condition, I will inform my dental office. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form. Since at each visit treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give my dental office my consent to perform any needed dental treatment. I understand that I am financially responsible for all charges whether covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered.

____ ______________________________________

Signature of patient, parent, guardian Date

____ ______________________________________

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments/Patient's Signature	Doctor's Signature
___________	________________________________	______________________
___________	________________________________	______________________
___________	________________________________	______________________