REGISTRATION FORM Section I: Patient Information

Date: _____
Name: _____ SSN: _____-____-_____
Date of Birth: _____

Address: _____ _____ City: _____ State: _____
Zip: _____
Phone: (_____) _____Work Phone: (_____) _____
Cell Phone: (_____) _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____Email:_____

Emergency Contact: _____ Phone: _____

Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party (if other than you)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____
Employer: _____ Work Phone (____) _____
SSN#: _____

Section III Insurance Information (if None, skip this section)

Name of Main Insured: _____ DOB: _____
Relationship to Patient: _____
SSN#:_____ Name of Employer: _____
Work Phone: (____) _____
Address of Employer: _____City: _____ State: _____
Zip: _____

Insurance Company: _____ Grp #: _____
ID#: _____

Ins Co Address: _____
Ins Co. Phone: _____

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Section IV **Dental History**

Name: _____

Reason for today's visit: _____

When was your last cleaning:

_____

Check if you have any problems with the following:

☐ Bleeding Gums ☐ Grinding Teeth ☐ Sores or growths in your mouth
☐ Clicking or popping of jaw ☐ Loose teeth or broken fillings ☐ Broken Teeth

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?

Section VI **Medications**

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section VI **Allergies (If none, Check None)**

☐ **None**

☐ Latex ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Sulfa
☐ Codeine ☐ Metal Allergies
☐ Local Anesthetic
☐ Aspirin

Other_____
_____
_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Doctor Signature: _____Date:_____

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Section V Medical History

Name: _____ Date:_____

Physician's Name: If none, write None. _____

Date of last Visit: _____

Physician's Phone number _____

Have you had any serious illnesses or operations? _____ If yes, please describe and date_____

_____

Have you had a history of radiation therapy? ☐ Yes ☐ No Dates, if applicable _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Dates, if applicable: _____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin etc.) _____

(Women) Are You Pregnant? ☐ Yes ☐ No How long? _____ Taking Birth Control? ☐ Yes ☐ No

Are you taking any bisphosphonates? (Actone, Fosamax) _____

Check if you have any of the following: Check None, if you don't have any of the following or Fill out Other Section.

☐ **None**

☐ Diabetes	☐ Hepatitis/Liver Problem	☐ Pacemaker	☐ Dialysis
☐ Artificial Heart Valve	☐ Epilepsy	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Heart Murmur	☐ HIV Positive	☐ Thyroid Problems
☐ Back Problems	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Stroke	☐ Excessive Bleeding	☐ Aids

☐ Heart Problems – Describe: _____

Do You Smoke? Yes/No How much per day? _____

Other/Notes:

_____

_____

_____

Patient Signature: _____

Doctor Signature: _____

Office USE ONLY BELOW:

Medical Release Necessary? _____ Physician #: _____

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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party-payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying to this consent.

1. Information to be Used or Disclosed:
   __ My dental records for the following date(s):_____ or
   __ Entire dental record
   __Include__ Exclude: My health information related to drug and/or alcohol abus
   __ Include __ Exclude: My health information related to HIV/AIDS
   __Other information to be used or disclose (describe information in detail): _____
   _____
2. Purpose of Use or Disclosure:

   __ Treatment, Payment or Dental Care Operations
   __ Disclosure to Life Insurer for Coverage Purposes
   __ Disclosure to Employer of results of pre-employment physical or lab tests
   __ Release to the Following Family Members:_____
   _____
   __ Other (describe each purpose of the requested use and disclosure in detail):

3. Person(s) Authorized to Make the Disclosure: _____

4. Person(s) Authorized to Receive the Disclosure: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Patient Name: _____Date: _____

Signature: _____ Date: _____

Relationship to Patient: _____

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