



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: _____



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

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: _____



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 #: _____



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: _____

2425 Brunello Trace Lutz, Fl 33558

luminasmiles@gmail.com 813-406-4848