

Affordable Dental Care

PATIENT REGISTRATION

Date: _____

Name: (please print) _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact Phone No.: _____ Secondary Contact Phone No.: _____

Date of Birth: _____ SSN# _____ DL#: _____

Male

Female

Married

Single

Divorced

Widowed

Primary Insurance: _____

Group Number: _____ Employer: _____

Policy Number: _____ Subscriber: _____

Relationship to Patient: _____

Secondary Insurance: _____

Group Number: _____ Employer: _____

Policy Number: _____ Subscriber: _____

Emergency Contact: _____ Phone Number: _____

Relative or Family Member a patient here? Y / N Name: _____

How did you hear about us? _____

Financial Responsibility (if not the patient):

Name: _____ Phone No.: _____ Relationship: _____

Address: _____ SSN#: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due prior to services being rendered.

Patient/Responsible Party's Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

MEDICAL HISTORY

Patient Name _____	
Patient Account No. _____	Medical Alert _____

- 1 Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
- 2 Have you taken any medication or drugs during the past two years? Yes No
- 3 Are you taking any medication, drugs or pills now? Yes No
 If yes, please list name and dosage _____
- 4 Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
 If yes, please list: _____
- 5 Have you been a patient in the hospital during the past five years? Yes No
- 6 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) _____	Yes	No	Asthma _____	Yes	No
Chest Pain _____	Yes	No	Hay Fever _____	Yes	No
Congenital Heart Disease _____	Yes	No	Latex Sensitivity _____	Yes	No
Heart Murmur _____	Yes	No	Allergies or Hives _____	Yes	No
High Blood Pressure _____	Yes	No	Sinus Trouble _____	Yes	No
Mitral Valve Prolapse _____	Yes	No	Radiation Therapy _____	Yes	No
Artificial Heart Valve _____	Yes	No	Chemotherapy _____	Yes	No
Heart Pacemaker _____	Yes	No	Tumors _____	Yes	No
Rheumatic Fever _____	Yes	No	Hepatitis A (infectious) B (serum) _____	Yes	No
Arthritis/Rheumatism _____	Yes	No	Venereal Disease _____	Yes	No
Cortisone Medicine _____	Yes	No	A.I.D.S. _____	Yes	No
Swollen Ankles _____	Yes	No	H.I.V. Positive _____	Yes	No
Stroke _____	Yes	No	Cold Sores/Fever Blisters _____	Yes	No
Diet (Special/ Restricted) _____	Yes	No	Blood Transfusion _____	Yes	No
Artificial Joints (hip, knee, etc.) _____	Yes	No	Hemophilia _____	Yes	No
Kidney Trouble _____	Yes	No	Sickle Cell Disease _____	Yes	No
Ulcers _____	Yes	No	Bruise Easily _____	Yes	No
Diabetes _____	Yes	No	Liver Disease _____	Yes	No
Thyroid Problems _____	Yes	No	Yellow Jaundice _____	Yes	No
Glaucoma _____	Yes	No	Neurological Disorders _____	Yes	No
Contact lenses _____	Yes	No	Epilepsy or Seizures _____	Yes	No
Emphysema _____	Yes	No	Fainting or Dizzy Spells _____	Yes	No
Chronic Cough _____	Yes	No	Nervous/Anxious _____	Yes	No
Tuberculosis _____	Yes	No	Psychiatric/Psychological Care _____	Yes	No

- 7 Do you use more than two pillows to sleep? Yes No
- 8 Have you lost or gained more than 10 pounds in the past year? Yes No
- 9 Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____
- 10 **Women:** Are you: **Pregnant?** Yes, _____ Months No **Nursing?** Yes No **Taking Birth Control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

DENTAL HISTORY

Patient Name _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____ What was done at your last dental visit? _____

Previous Dentist's Name _____ Address _____ State _____
Zip _____
Telephone _____

How often do you have dental examinations? _____

Do you have any dental problems now? _____

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad taste? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? Yes No

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____