PATIENT REGISTRATION

ID: ________ Chart ID: ________

First Name: ________ Last Name: ________ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ________ Last Name: ________ Middle Initial: ____

Address: ________ Address 2: ________

City, State, Zip: ________

Home Phone: ________ Work Phone: ________ Ext: ________ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ________ Address 2: ________

City: State / Zip:

Home Phone: ________ Work Phone: ________ Ext: Cellular: ________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ________ Age: ________ Soc. Sec: ________ Drivers Lic: ________

E-mail: ________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ________ Pref. Dentist: ________

Employer ID: ________ Pref. Pharmacy: ________

Carrier ID: ________ Pref. Hyg.: ________

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______________________________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________________

Comments: ______________________________
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________

HISTORIA MEDICA

Nombre del paciente:_ _ _ _ _ _ _ _ _ _
Fecha de nacimiento:_ _ _ _ _ _

Aunque el personal dental principalmente tratan el area y alrededor de su boca, su boca es una parte de su cuerpo. Los problemas de salud que pueda tener, o medicamentos que este tomando, podrian tener una importante relaci6n con la odontologia que usted recibira. Gracias por contestar las siguientes preguntas.

IEsta usted bajo el cuidado de un medico ahora? ☐Si ☐No En caso afirmativo, sirvase explicar:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

IAlguna vez ha sido hospitalizado o tenido una operaci6n mayor? ☐Si ☐No En caso afirmativo, sirvase explicar:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

IHa tenido alguna vez una lesion grave en la cabeza o en el cuello? ☐Si ☐No En caso afirmativo, sirvase explicar:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

IEsta usted tomando algun medicamento, pastillas, o drogas? ☐Si ☐No En caso afirmativo, sirvase explicar:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I Toma o ha tornado, Phen-Fen o Redux? ☐Si ☐No

Alguna vez a tornado Fosamax, Boniva, Actonel,o cualquier otro medicamento que contenga bifosfonatos? ☐Si ☐No

Esta usted en una dieta especial? ☐Si ☐No

I Usa tabaco? ☐Si ☐No

IListed usa sustancias controladas? ☐Si ☐No

Mujeres: IEsta usted
Embarazada o tratando de quedar embarazada? ☐Si ☐No Toma anticonceptivos orales? ☐Si ☐No Esta amamantando? ☐Si ☐No

Es usted alergico a cualquiera de los siguiente?
☐Aspirina ☐Penicilina ☐Codeina ☐Acrilico ☐Metalico ☐Latex ☐Anestesicos locales Sulfamida
☐Otros En caso afirmativo, sirvase explicar:_ _

I Tiene, o ha tenido, cualquiera de los siguientes?

SIDA/ HIV Positive	☐Si ☐No	Cortisona	☐Si ☐No	Hemofilia	☐Si ☐No	Tratamiento con radiacion	☐Si ☐No
Enfermedad de Alzheimer's	☐Si ☐No	Diabetes	☐Si ☐No	Hepatitis A	☐Si ☐No	Perdida de peso reciente	☐Si ☐No
Anafilaxia	☐Si ☐No	Drogadiccion	☐Si ☐No	Hepatitis B o C	☐Si ☐No	Dialisis renal	☐Si ☐No
Anemia	☐Si ☐No	Facilmente pierde el aliento	☐Si ☐No	Herpes	☐Si ☐No	Fiebre reumatica	☐Si ☐No
Angina	☐Si ☐No	Enfisema	☐Si ☐No	Presion arterial alta	☐Si ☐No	Reumatismo	☐Si ☐No
Artritis/Gota	☐Si ☐No	Epilepsia o convulsiones	☐Si ☐No	Colesterol Alto	☐Si ☐No	Escarlatina	☐Si ☐No
Valvula del corazon artificial	☐Si ☐No	Sangrado excesivo	☐Si ☐No	Ronchas o erupcion cutanea	☐Si ☐No	Herpes	☐Si ☐No
Articulacion artificial	☐Si ☐No	Sed excesiva	☐Si ☐No	Hipoglucemia	☐Si ☐No	Enfermedad de celulas falciformes	☐Si ☐No
Asma	☐Si ☐No	Desmayos I vertigo	☐Si ☐No	Latido irregular del corazon	☐Si ☐No	Problemas del seno nasal	☐Si ☐No
Enfermedad arterial	☐Si ☐No	Tos frecuente	☐Si ☐No	Problemas de los rinones	☐Si ☐No	Espina Bifida	☐Si ☐No
Transfusion de sangre	☐Si ☐No	Diarrea frecuente	☐Si ☐No	Leucemia	☐Si ☐No	Enfermedad estomacal/intestinal	☐Si ☐No
Problemas respiratorio	☐Si ☐No	Dolores de cabeza frecuente	☐Si ☐No	Enfermedades del Higado	☐Si ☐No	Ataque fulminante	☐Si ☐No
Cancer	☐Si ☐No	Glaucomas	☐Si ☐No	Presion arterial baja	☐Si ☐No	Hinchaz6n de las extremidades	☐Si ☐No
Moretonescon facilidad	☐Si ☐No	Herpes Genital	☐Si ☐No	Enfermedad pulmonar	☐Si ☐No	Enfermedad de la Tiroides	☐Si ☐No
Quimioterapia	☐Si ☐No	Fiebre del heno	☐Si ☐No	Prolapse de la valvula mitral	☐Si ☐No	Amigdalitis	☐Si ☐No
Dolores en el pecho	☐Si ☐No	Ataque/Falla del corazon	☐Si ☐No	Osteoporosis	☐Si ☐No	Tuberculosis	☐Si ☐No
Herpes labial/Fiebre Ampollas	☐Si ☐No	Soplo cardiaco	☐Si ☐No	Dolor en la articulacion de la quijada	☐Si ☐No	Tumores o crecimientos	☐Si ☐No
Cardiopatia congenita	☐Si ☐No	Marcapasos en el Corazon	☐Si ☐No	Enfermedad paratiroidea	☐Si ☐No	Ulceras	☐Si ☐No
Convulsiones	☐Si ☐No	Problemas/Enfermedad del coraz6n	☐Si ☐No	Atencion Psiquiatrica	☐Si ☐No	Enfermedad venerea	☐Si ☐No
						La ictericia amarilla	☐Si ☐No

I,Ha tenido alguna enfermedad grave que no figura en la lista de arriba? ☐Si ☐No En caso afirmativo, sirvase explicar:_ _

Comentarios: ---

En lo mejor de mi conocimiento, las preguntas de este cuestionario se han contestado correctamente. Entiendo que el proporcionar informaci6n incorrecta puede ser peligroso para mi salud (o del paciente). Es mi responsabilidad informar a la oficina dental de cualquier cambio en el estado medico.

Firma del paciente, padre o tutor_ Fecha_ _ _ _ _ _ _ _ _

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NAME: ____________________

ADDRESS: ____________________

TELEPHONE: ____________________ EMAIL: ____________________

SOCIAL SECURTY# : ____________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 our 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 your 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON: ____________________

Telephone: ____________________

E-MAIL ____________________

ADDRESS ____________________

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: ____________________ Date: ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, ____________________, have received a copy of this office's Notice of Privacy Practices.

____

PLEASE PRINT NAME

`

____

SIGNATURE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____________________