Date

PATIENT REGISTRATION

Patient's Name _____ Birthdate _____ Sex ☐ M ☐ F

Patient's Address _____ (Street) (City) (Zip) Phone _____

Patient's Employer _____ Business Address _____ Phone _____

No. of Yrs. Employed ____ Soc. Sec. No. _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse _____ No. of Dependents _____ Spouse's Soc. Sec. No. _____

Spouse's Employer _____ Whom May We Thank For Referring You _____

Nearest Neighbor or Relative's Name, Address, and Phone No. _____

Who Will Pay This Account? (Whose Name Will Appear on Billing Statement.)
☐ Self ☐ Spouse ☐ Parent or Guardian

If you Checked "Self" Please Skip Next Section and Continue with Insurance Section

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name _____ Birthdate _____ Sex ☐ M ☐ F

Street Address (If Dif. Than Above) _____ (Street) (City) (State) (Zip) Phone _____

Responsible Party's Employer _____ No. of Years Employed _____ Soc. Sec. No. _____

Business Address _____ Phone _____

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Subscriber's Employer _____ Business Address _____ Insurance Co. _____

Group No. _____ Deductible ☐ Yes ☐ No Max. Benefit _____ Benefit Year _____

Patients Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent Have You Used Your Dental Insurance Previously? ☐ Yes ☐ No

Are You Covered Under More Than One Dental Plan? ☐ Yes ☐ No If Yes, Please Fill Out Next Section.

SECONDARY INSURANCE

Subscriber's Name _____ Birthdate _____ Soc. Sec. No _____

Insurance Co. _____ Group No _____ Employer _____ Relationship to Patient _____

(Please Continue On Next Page)

FOR OFFICE USE ONLY

Primary Subscriber's Name _____ Family Member No. _____ Emp. No. _____

Secondary Subscriber's Name _____ Family Member No. _____ Emp. No. _____

Doctor _____

Medical Message:

1. No Message 2. See Meoical 3. Premedicate 4. See Medical and Premedicate 5. Allergies

MEDICAL HISTORY

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of physician _____

_____

Last complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
VD (Syphilis, Gonorrhea)	Yes ☐	No ☐	Serious Accident	Yes ☐	No ☐
Aids	Yes ☐	No ☐			

Have you ever been treated (other than diagnostic) with x-ray? Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ _____

Are you subject to prolonged bleeding? Yes ☐ No ☐

Are you subject to fainting spells? Yes ☐ No ☐

(Women) Are you pregnant? Yes ☐ No ☐ How long? _____

DENTAL HISTORY

Date of last dental visit? _____ Dentist's Name _____ Phone _____

Did you have x-rays taken? Yes ☐ No ☐

Have you had all your teeth x-rayed in the past 3 years? Yes ☐ No ☐

Do you wear full or partial dentures? Yes ☐ No ☐ (If Yes) How old are they? _____

Does any member of your family, including your parents, wear dentures? Yes ☐ No ☐

Are you dissatisfied with the appearance of your teeth? Yes ☐ No ☐

Have you had orthodontic treatment? Yes ☐ No ☐

Do you clench or grind your teeth during the day or night? Yes ☐ No ☐

Have you ever had pain in your jaw joint or your face (In and about your ears)? Yes ☐ No ☐

Does your jaw joint click? Yes ☐ No ☐ Do you have difficulty opening your mouth widely? Yes ☐ No ☐

Do you have an unpleasant odor, or taste, in your mouth? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Have you had gum disease or pyorrhea? Yes ☐ No ☐

Is your mouth or teeth sensitive to: Pressure Yes ☐ No ☐ Cold Yes ☐ No ☐ Hot Yes ☐ No ☐

Does food catch between your teeth? Yes ☐ No ☐

Please add anything you feel is important for the doctor to know _____

_____

_____

We may request / report credit information to T.R.W., a credit rating institution.

Patient's Signature _____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ___/___/___

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

_____

_____

I hereby authorize _____
Name of individual(s) and/or organization providing information

to release the above-described information to _____.
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not
Expiration date or event
specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: ___/___/___