Adult Patient Registration

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below then include your signature and date.

Patient's Name ______________________________ Soc. Sec. # ______________

Male ☐ Female ☐ Birthdate ______________ Age __________ Single ☐ Married ☐

Address: ____

City: ______________________________ State: __________ Zip Code: __________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address: ____

Patient Employer: ______________________________ Occupation: ______________

Whom may we thank for referring you? ____

Notify in case of Emergency: ______________________________ Relationship to you: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Primary Insurance

Person Responsible for account: ______________________________ Relationship: ______________

Birthdate: ______________ Soc. Sec. # ______________ Are they a patient here? Yes ☐ No ☐

Address: ____

City: ______________________________ State: __________ Zip Code: __________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Insured Employed by: ______________________________ Occupation: ______________

Insurance Company: ______________________________ Phone: ______________

Subscriber Number: ______________________________ Group Number: ______________

Name(s) of other dependents on this plan: ____

Dental History

Former Dentist: ______________________________ Phone: ______________

Date of last visit: ______________________________ Date of last x-rays: ______________

Check if you have any of the following:

____ Bad Breath
____ Bleeding Gums
____ Sensitivity to Cold
____ Sensitivity to Hot
____ Food collection between teeth
____ Grinding or Clenching teeth
____ Loose teeth or Broken fillings
____ Biting sensitivity
____ Periodontal treatment
____ Clicking or popping jaw
____ Sores or Growths in mouth
____ Sensitivity to Sweet

How often do you brush? ______________________ How often do you floss? ______________________

How do you feel about the appearance of your teeth? ____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ______________________

Additional information about your dental health or previous treatment? ______________________________

Reason for your visit today? ____

ADULT MEDICAL HISTORY

Patient Name:(Print) ______________________________ **Date of Birth:** ______________

Do you have or have you had any of the following? (If YES, Please Check)

☐ Abnormal Bleeding -(after extraction / surgery / trauma)
☐ Herpes
☐ Seasonal Allergies

☐ A-Fib / Heart Palpitations	☐ Cancer / Chemo / Radiation	☐ High Blood Pressure	☐ Shingles
☐ AIDS / HIV Positive	☐ Cold Sores / Fever Blisters	☐ Hives / Rash	☐ Sinus Problems
☐ Alzheimer's / Dementia	☐ Convulsions	☐ Kidney Disease	☐ Stent
☐ Anemia / Blood Disorders	☐ Depression	☐ Lung Disease	☐ Stroke
☐ Anxiety	☐ Diabetes / Hypoglycemia	☐ Migraines / Frequent Headaches	☐ TMJ
☐ Arthritis	☐ Drug / Alcohol Abuse	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Artifical Joints (explain below)	☐ Epilepsy / Seizures / Fainting	☐ Neurological Condition	☐ Tuberculosis
☐ Artifical Valve (explain below)	☐ Hearing Problems	☐ Osteoporosis	☐ Tumor / Growths
☐ Asthma / Breathing Problems	☐ Heart Bypass	☐ Pacemaker	☐ Venereal Disease
☐ Autoimmune Disease	☐ Heart Murmur	☐ Psychiatric Care	
☐ Blood Transfusion	☐ Hepatitis / Other Liver Disease	☐ Rheumatic / Scarlet Fever	

Do you have any disease, condition or problem not listed above? ______________________________

Are you allergic to, or have you reacted adversely to any of the following? (If YES, Please Check)

☐ Aspirin	☐ Latex Materials	☐ Sulfa Drugs
☐ Barbiturates, Sedatives, Sleeping Pills	☐ Local Anesthetics (Novocaine)	☐ Other: ______________
☐ Codeine or Orther Narcotics	☐ Penicillin or Other Antibotics	

Are you taking any of the following? (If YES, Please Check)

☐ Antibiotics or Sulfa Drugs	☐ Birth Control	☐ Insulin or Other Diabetes Medication
☐ Anticoagulants (Blood Thinners)	☐ Controlled Substance	☐ Nitroglycerin
☐ Antidepressants or Tranquilizers	☐ Cortisone or Other Steroids	☐ Osteoporosis Medicine for Bone Density
☐ Aspirin	☐ High Blood Pressure Medication	☐ Tobacco Use

Primary Care Physician: ______________________________

SURGERIES: (List ALL in the past 5 years) ______________________________

ARTIFICAL JOINT / VALVE DETAILS: Date of Surgery: ______________ Location of Joint / Valve: ______________

Have you ever been told you require Pre-Medication prior to dental procedures? (please check) ______ YES or ______NO

MEDICATIONS: (List ALL Current) ______________________________

List any changes to the following: Address / Phone Number / Pharmacy / Insurance ______________________________

____

Signature of Patient: ______________________________ **Date:** ______________

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 your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices. I understand this notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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 the notice.

______________________________ _______________

Patient Signature Date

______________________________ _______________

Print Patient Name Birthdate

I wish to be contacted in the following manner (check all that apply):

Home Telephone ____________________

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone ____________________

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Written Communication

☐ Okay to mail to my home address

☐ Okay to mail to my work/office address

☐ Okay to fax to this number

☐ Other _______________

____

CONSENT FOR TREATMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: ______________________________ Date: ________________

INSURANCE AUTHORIZATION

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature: ______________________________ Date: ________________