Patient Registration

Date _____ Home Phone _____

Email Address _____ Cell Phone _____

Patient's Name [Mr/Mrs/Ms/Dr]_____ Preferred _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: ▫ M ▫ F Date of Birth _____ Age _____ ▫ Single ▫ Married ▫ Widowed ▫ Divorced ▫ Separated

Employer _____ Occupation _____SSN_____

Business Address _____ Business Phone _____

Spouse's Information:

Name _____ Date of Birth _____ SSN _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Name of Dental Insurance _____ Group Number _____

Emergency Contact _____ Phone _____ Relationship _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, (print name)_____, have received a copy of this office's Notice of Privacy Practices.

Under the requirements of HIPAA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have any of your medical/dental information released to family members or friends, please list the individual(s) below:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

How would you like for us to communicate with you? Our dental office sends appointment reminders, information about treatment, insurance information and other communications.

Preferred method of contact (check all that apply):

▫ Contact me by phone at: ▫ Home _____

▫ Cell _____

▫ Work _____

▫ Text Me ▫ Email me ▫ Do not contact

For Phone, Text and Email Communications:
By signing below, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Signature _____ Date _____

Office use only: We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, receipt could not be obtained due to: ▫ Refusal to sign ▫ Consent revoked ▫ Emergency situation ▫ Communication barriers

Date/Initials: _____/_____

Medical History

Physician's Name _____ Phone Number _____ Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Women: Are you pregnant? ▫ Yes ▫ No Nursing? ▫ Yes ▫ No Taking birth control pills? ▫ Yes ▫ No

Have you had or have any of the following:

- ▫ **AIDS/HIV Positive**
- ▫ **Arthritis**
- ▫ **Artificial Heart Valve**
  If so, when? _____
- ▫ **Artificial Joint**
  If so, when? _____
- ▫ **Asthma**
- ▫ **Blood Disorder**
  - ▫ **Anemia**
  - ▫ **Hemophilia**
  - ▫ **Other_____**
- ▫ **Cancer**
  Type: _____
- ▫ **Chemical Dependency**
- ▫ **Chemotherapy**
- ▫ **Cortisone Treatment**
- ▫ **Cough, persistent**
- ▫ **Diabetes**
- ▫ **Epilepsy**
- ▫ **Fainting**
- ▫ **Gastrointestinal**
  - ▫ **Acid Reflux**
  - ▫ **Other _____**
- ▫ **Headaches**
- ▫ **Hepatitis**
- ▫ **Heart Problems**
  Type:_____
- ▫ **High Blood Pressure**
- ▫ **High Cholesterol**
- ▫ **Kidney Disease**
- ▫ **Lyme Disease**
- ▫ **Nervous System Problems**
- ▫ **Osteoporosis**
- ▫ **Pacemaker**
- ▫ **Psychiatric Care**
- ▫ **Radiation Treatment**
- ▫ **Respiratory Disease**
- ▫ **Sleep Apnea**
  - ▫ **CPAP**
- ▫ **Shortness of Breath**
- ▫ **Snoring**
- ▫ **Stroke**
- ▫ **Swelling of Feet/Ankle**
- ▫ **Thyroid Problems**
- ▫ **Tobacco Habit**
  Frequency _____
- ▫ **Tuberculosis**
- ▫ **Ulcer**

List of Medications

- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____
- ❖ _____

Drug Allergies

- ☐ Penicillin/Amoxicillin
  Reaction: _____
- ☐ Erythromycin
  Reaction: _____
- ☐ Clindamycin
  Reaction: _____
- ☐ Codeine
  Reaction: _____
- ☐ Local Anesthetic
  Reaction: _____
- ☐ Sulfa
  Reaction: _____
- ☐ Latex
  Reaction: _____
- ☐ Other _____
  Reaction: _____

Pharmacy _____ Address _____ Phone Number _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ Date _____