PATIENT REGISTRATION AND INFORMATION FORM

Today's Date_____Have you been seen in our office before?_____When?_____

PATIENT INFORMATION

Name_____ Birth Date_____ Age_____ Sex_____

Address_____ Social Security#_____

City_____ State_____ Zip_____ Marital Status: S_____ M_____ D_____ W_____ Sep_____

Home Phone ( ) _____ Employer_____

Work Phone ( ) _____ Cell( ) _____ Address_____

Emergency Phone & Contact_____ City_____ State_____ Zip_____

_____ Dentist's Name_____

Referred By_____ Physician's Name_____

What is the reason for your visit? _____ College (if student)_____

BILLING INFORMATION

Name_____ Relationship to Patient_____

Address_____ Occupation_____

City _____State _____Zip_____ Employer_____

Home Phone ( )_____ Address_____

Work Phone ( )_____ City _____State _____Zip_____

INSURANCE INFORMATION

Policy Holder's Name_____ Employer_____

Insurance Company_____ Address_____

Policy Holder's Soc Security #_____ Birth Date_____

Policy Holder's Certificate or ID# _____ Group #_____

SECONDARY INSURANCE INFORMATION (if applicable)

Policy Holder's Name_____ Employer_____

Insurance Company_____ Address_____

Address_____ City _____State _____Zip_____

Policy Holder's Soc Security #_____ Birth Date_____

Policy Holder's Certificate # or ID_____ Group #_____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING Y (yes) or N (no)
ALL RESPONSES WILL REMAIN CONFIDENTIAL

1. **Are you in good health?**.....Y N
2. **Has there been ANY change in your general health in the past year?**.....Y N
   If yes, please describe:_____
3. **Are you now under a physician's care for a particular problem?**.....Y N
   If yes, please describe:_____
4. **Have you had any serious illnesses, operations or hospitalizations?** If yes, describe:.....Y N
5. **Do you smoke?**.....Y N
6. **Do you have or have you ever had:**
   a. Rheumatic fever or rheumatic heart disease?.....Y N
   b. Congenital heart disease?.....Y N
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, mitral valve)?...Y N
      If yes, please describe:_____
   d. Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?.....Y N
      If yes, please describe:_____
   e. Neurological-psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown)?.....Y N
      If yes, please describe: _____
   f. Blood disease (anemia, bleeding tendency, blood transfusion? Do you bruise easily)?.....Y N
      If yes, please describe: _____
   g. Liver disease (jaundice, hepatitis)?.....Y N
   h. Kidney disease?.....Y N
   i. Diabetes?.....Y N
   j. Thyroid disease (goiter)?.....Y N
   k. Implants placed anywhere in your body (heart, valve, knee, hip, etc.)?.....Y N
   l. Cancer?.....Y N
7. **Do you have:**
   a. Stomach ulcers or colitis?.....Y N
   b. Sinus or nasal problems?.....Y N
   c. Any disease, drugs, or transplant operation that has depressed your immune system?.....Y N
   d. Recurrent infections of any kind?.....Y N
   e. Problems with anesthesia of any kind?.....Y N
   f. Sexually transmitted disease?.....Y N
   g. H.I.V. positive?.....Y N
8. **Dental History**
   a. When was your last dental check-up? _____
   b. Were x-rays taken?.....Y N
   c. Do your gums bleed?.....Y N
   d. Do you have sore or sensitive teeth?.....Y N
   e. Do you have any sores, swelling, or fever blisters in your mouth?.....Y N
   f. Temporomandibular joint problems?.....Y N
      (popping or clicking of jaw joints, pain near ear, difficulty opening mouth, grind or clench teeth).....Y N
   g. Are you happy with how your teeth look?.....Y N
   h. Are you happy with the color of your teeth?.....Y N
   i. What would you change, if anything, about your teeth?
9. **Please list ALL MEDICATIONS you are taking:**_____
10. **Please list all DRUG ALLERGIES:**_____
11. **Do you have any other disease, condition or problem not listed above that you think the doctor should be made aware of?** If yes, please describe:.....Y N
12. **Do you wish to talk to the doctor privately about anything?**.....Y N
13. **Women: Are you pregnant or planning pregnancy?**.....Y N
    Are you taking birth control pills?.....Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

I consent to treatment as necessary or desirable to the care of the patient named, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-rays, or other studies that may be used by the attending doctor or his assistant, or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made with the Financial Department.

_____
Signature of Patient, Parent or Agent (Must be 18 yrs or older)

_____ _____
Date Dr.'s Initials

I, _____, hereby acknowledge that I am aware of the Notice of HIPAA Privacy Practices. Any information provided to them on my behalf will be kept confidential. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

PATIENT **DATE**

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