



**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last, First MI (Preferred Name)

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Email: \_\_\_\_\_ Gender:  Male  Female Family Status:  Single  Married  Child

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Drivers License # \_\_\_\_\_ **\*\*Office Use only: Copy in file?  Yes  No**

**\*\*HIPPA\*\*:** Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

Home Phone: \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  Yes  No Best time to call: \_\_\_\_\_  
Cell Text Message: \_\_\_\_\_  Yes  No  
E-mail: \_\_\_\_\_  Yes  No  
Pager: \_\_\_\_\_  Yes  No  
Fax: \_\_\_\_\_  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip Code Phone

In case of an emergency, contact: \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY/GUARANTOR INFORMATION**

Only if the person responsible for this account is **NOT** the patient, complete the following information for the **Guarantor**:

Guarantor Name: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

Gender:  Male  Female Family Status:  Married  Single  Divorced  Child  Other \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Drivers License # \_\_\_\_\_ **\*\*Office Use only: Copy in file?  Yes  No**

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Pager: \_\_\_\_\_  
Cell: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_  
Street City State Zip Code Phone

**REFERRAL INFORMATION**

How did you learn about, or who referred you to, our dental office?  Patient/friend  Our Staff,  Another Dental Office,  Yellow Pages,  Insurance Plan,  Newspaper,  TV,  Website,  Newsletter,  School,  Your employer  Direct Mail Postcard  Other \_\_\_\_\_

Name of person or dental or medical office who referred you: \_\_\_\_\_

## INSURANCE INFORMATION

### Primary Insurance

Name of Primary Subscriber/Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date Employed \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier/Plan Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street City State Zip Code Phone

### Medical Insurance

Name of Primary Subscriber/Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No

Relationship to Patient:  Self  Spouse  Child  Legal Guardian  Other \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date Employed \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier/Plan Name: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street City State Zip Code Phone

## PATIENT'S HEALTH INFORMATION

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

### Have you ever had any of the following health problems, conditions or habits?

- |   |  |  |  |
|---|--|--|--|
| <p><b>Y N</b></p> <input type="checkbox"/> AIDS<br><input type="checkbox"/> Allergy (Codeine)<br><input type="checkbox"/> Allergy (Penicillin)<br><input type="checkbox"/> Allergy Other _____<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis, Rheumatism<br><input type="checkbox"/> Artificial Heart Valves<br><input type="checkbox"/> Artificial Joints, Pins...<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Back Problems<br><input type="checkbox"/> Bleeding Abnormally<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemical Dependency<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Circulatory Problems<br><input type="checkbox"/> Congenital Heart Defect<br><input type="checkbox"/> Cortisone Treatments<br><input type="checkbox"/> Cough, Persistent | <p><b>Y N</b></p> <input type="checkbox"/> Cough up blood<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Growths<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Head Injuries<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia Repair<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Jaw Pain | <p><b>Y N</b></p> <input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> <b>Pregnancy</b><br>Due date: _____<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Sexually transmitted disease (including HIV/AIDS)<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Skin rash<br><input type="checkbox"/> Smoking ___/day ___/year | <p><b>Y N</b></p> <input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Swelling of feet/ankles<br><input type="checkbox"/> Substance Abuse<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Tobacco Habit<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Other: |
|---|--|--|--|

### Have you ever had any of the following dental problems or conditions? Please check those that apply:

- |  |  |   |   |
|--|--|---|---|
| <p><b>Y N</b></p> <input type="checkbox"/> Bad Breath<br><input type="checkbox"/> Bad Taste<br><input type="checkbox"/> Bleeding Gums<br><input type="checkbox"/> Clicking/popping of jaw<br><input type="checkbox"/> Food caught in teeth | <p><b>Y N</b></p> <input type="checkbox"/> Grinding or clenching teeth<br><input type="checkbox"/> Loose teeth<br><input type="checkbox"/> Broken Fillings<br><input type="checkbox"/> Periodontal treatment<br><input type="checkbox"/> Sensitivity to cold | <p><b>Y N</b></p> <input type="checkbox"/> Sensitivity to sweets<br><input type="checkbox"/> Sensitivity to hot<br><input type="checkbox"/> Sensitivity when biting<br><input type="checkbox"/> Sores/growth in the mouth<br><input type="checkbox"/> Local Anesthetic-Novocain | <p><b>Y N</b></p> <input type="checkbox"/> Nitrous Oxide<br><input type="checkbox"/> Prolonged bleeding<br><input type="checkbox"/> General Anesthetic<br><input type="checkbox"/> Extractions<br><input type="checkbox"/> Braces |
|--|--|---|---|

### Please answer the following dental/medical questions:

- Have you ever been, or do you need to be, pre-medicated for dental work?  Yes  No
- How often do you floss? \_\_\_\_\_





HIPAA COMPLIANCE FORM

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: (Please print)

LAST NAME FIRST NAME MIDDLE
1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes No

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information Yes No
Billing Information Yes No
Dental/Medical Information Yes No

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information Yes No
Billing Information Yes No
Dental/Medical Information Yes No

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information Yes No
Billing Information Yes No
Dental/Medical Information Yes No

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information Yes No
Billing Information Yes No
Dental/Medical Information Yes No

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information Yes No
Billing Information Yes No
Dental/Medical Information Yes No

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: Name:

DATE:

SIGNED:

WITNESS:

Print Name:

Print Name: