

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder**Patient Information**

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____

☐ I would like to receive correspondences via e-mail.**Section 2**Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____

Pref. Dentist: _____

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Pref. Hyg: _____

Section 3

Emergency Contact _____

Emergency Phone # _____

Address _____

City/State _____

Phone #2 _____

Relationship _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

NEW MEDICAL HISTORY 9/2019

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If yes	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	
Are you currently taking Coumadin, Warfarin, Eliquis, Plavix or any other blood thinner?	☐ Yes ☐ No	If yes	
Have you ever been told you need to premedicate with antibiotics prior to dental treatment?	☐ Yes ☐ No		
Do you have any dental problems?	☐ Yes ☐ No	If yes	
Are you happy with your smile?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant?	☐ Nursing?	☐ Taking oral contraceptives?
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Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfur Drugs	☐ Local Anesthetics
☐ Ibuprofen	☐ Clindamycin		

Any other Allergies not listed above?

☐ Yes ☐ No

If yes

Do you use controlled substances?

☐ Yes ☐ No

If yes

Are you Taking any Medications? If Yes, Please list:

☐ Yes ☐ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cold Sores/ Fever Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

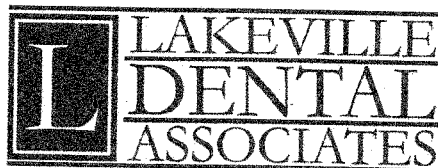
Any other medical conditions not listed above:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____



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lakevilledental54@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of the office's
Notice of Privacy Practices.

Print name: _____

Signature _____

Date ____ / ____ / ____

____ For Office Use Only _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but the acknowledgement could not be obtained because:

- ____ Individual refused to sign
- ____ Communication barriers prohibited obtaining the acknowledgement
- ____ An emergency situation prevented us from obtaining acknowledgement
- ____ Other (please specify) _____



SUPPLEMENTAL INFORMED CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have undertaken measures to accommodate social distancing in our practice, due to the nature of the procedures we provide, it is not possible at all times to maintain social distancing between the patient, the dentist, the clinical staff, and on occasion, among other patients.

By checking "**Yes**" below, I am hereby acknowledging that I understand that by receiving treatment in your office there is a risk of exposure to the Coronavirus; I have considered that risk of exposure to the Coronavirus and, after careful deliberation, I hereby accept that risk and I hereby consent to treatment in your office

By checking "**No**" below, I do not consent to receiving treatment in your office and I understand that absent my consent you will not provide me with treatment in your office

☐ Yes

☐ No

Print Name

Patient/Guardian's Signature

Date