

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

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

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: _____

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES NO

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing.....	☐	☐	Do you bite your lips or cheeks frequently.....	☐	☐
Are your teeth sensitive to hot or cold liquids/foods.....	☐	☐	Have you noticed any loosening of your teeth.....	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods.....	☐	☐	Does food tend to become caught between your teeth.....	☐	☐
Do any of your teeth feel painful.....	☐	☐	Have you ever had periodontal treatment (gums).....	☐	☐
Do you have any sores or lumps in or near your mouth.....	☐	☐	Have you ever worn a bite plate or other appliance.....	☐	☐
Have you had any head, neck, or jaw injuries.....	☐	☐	Have you had any difficult extractions in the past.....	☐	☐
Have you experienced any of the following problems			Have you ever had any prolonged bleeding following Extractions.....	☐	☐
Clicking in your jaw.....	☐	☐	Do you wear dentures or partials.....	☐	☐
Pain (joint, ear, side of face).....	☐	☐	If yes, give the date they were placed		
Difficulty in opening or closing your jaw.....	☐	☐			
Difficulty in chewing.....	☐	☐			
Do you have frequent headaches.....	☐	☐			
Do you clench or grind your teeth.....	☐	☐	Have you ever received oral hygiene instructions regarding the care of your teeth and gums.....	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR	DATE
DOCTOR'S SIGNATURE	DATE
DOCTOR'S COMMENTS	

Dr Charles Brown
MEDICAL HISTORY

PATIENT NAME _____ DATE _____

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, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, please list: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women. Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No

Alzheimer's Disease ☐ Yes ☐ No

Anaphylaxis ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Angina ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Artificial Heart Valve ☐ Yes ☐ No

Artificial Joint ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Blood Disease ☐ Yes ☐ No

Breathing Problem ☐ Yes ☐ No

Bruise Easily ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Chemotherapy ☐ Yes ☐ No

Chest Pains ☐ Yes ☐ No

Cold Sores/Fever Blisters ☐ Yes ☐ No

Congenital Heart Disorder ☐ Yes ☐ No

Cortisone Medicine ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Drug Addiction ☐ Yes ☐ No

Emphysema ☐ Yes ☐ No

Epilepsy or Seizures ☐ Yes ☐ No

Excessive Bleeding ☐ Yes ☐ No

Excessive Thirst ☐ Yes ☐ No

Fainting Spells/Dizziness ☐ Yes ☐ No

Frequent Cough ☐ Yes ☐ No

Frequent Headaches ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Gout ☐ Yes ☐ No

Heart Attack/Failure ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Heart Pacemaker ☐ Yes ☐ No

Heart Trouble/Disease ☐ Yes ☐ No

Hepatitis A ☐ Yes ☐ No

Hepatitis B or C ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Hives or Rash ☐ Yes ☐ No

Hypoglycemia ☐ Yes ☐ No

Irregular Heartbeat ☐ Yes ☐ No

Kidney Problems ☐ Yes ☐ No

Leukemia ☐ Yes ☐ No

Liver Disease ☐ Yes ☐ No

Low Blood Pressure ☐ Yes ☐ No

Lung Disease ☐ Yes ☐ No

Mitral Valve Prolapse ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Pain in Jaw Joints ☐ Yes ☐ No

Psychiatric Care ☐ Yes ☐ No

Radiation Treatments ☐ Yes ☐ No

Recent Weight Loss ☐ Yes ☐ No

Renal Dialysis ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Shingles ☐ Yes ☐ No

Sinus Trouble ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Swelling of Limbs ☐ Yes ☐ No

Thyroid Disease ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Tumors or Growths ☐ Yes ☐ No

Ulcers ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: _____

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 _____ DATE _____

CHARLES C. BROWN, JR., D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: _____

Staff Member Signature

Date