Patient Registration

Patient information

Name: _________________ ____ ________________ **Birthdate:** ____________ Social Security #: ____________

FIRST NAME MI LAST NAME

Address: ____ City: ________________ Zip Code: _________

Gender: Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: __________________ Occupation: ____________________ Work Phone: ________________________

Home Phone: ____________________ Cell Phone: ______________________ Email: _______________________

Referral source: ____

If Patient is a minor, please complete the following:

Name of person responsible for this account: _______________________ Relationship to patient: ______________

Address: _______________________________________ City: __________________ Zip Code: _______________

Cell Phone: ____________________________ Birthdate: _______________ Social Security #: _________________

Employer: ________________________ Occupation: ______________________ Work phone: _________________

General Information:

Orthodontist: _______________________________ Address: ____

Other doctors involved in dental care: ____

Primary Care Physician: _____________________________________ Address:: ___________________________

Emergency Contact: ________________________ Relationship: _______________ Phone number: ____________

Insurance Information:

Primary Insurance Company: _______________________ Secondary Insurance Company: ___________________

Policy Holder: ______________________ DOB: __________ Policy Holder: __________________ DOB: ________

Patient's Relationship to PolicyHolder: __________________ Patient's Relationship to PolicyHolder: _____________

Social Security # or ID #: __________________________ Social Security # or ID #: __________________________

Medical Insurance Company: _______________________ Policy Holder: _________________ DOB: ____________

Patient's relationship to PolicyHolder: ____________________ Social Security # or ID #: ______________________

Patient Name: ________________________ _____ ___________________________ Date: _______________
First Name MI Last Name

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Heart problems .... Yes □ No □

If yes, please describe: __________________________________

High Blood Pressure .... Yes □ No □

Low Blood Pressure .... Yes □ No □

Pacemaker .... Yes □ No □

Artificial Heart Valve .... Yes □ No □

Joint Replacement .... Yes □ No □

If yes, please describe __________________________________

Is an antibiotic premed required before treatment? Yes □ No □

If so, what type/dosage? _________________________________

Easy Bruising .... Yes □ No □

Abnormal Bleeding .... Yes □ No □

Frequent Nose Bleeds .... Yes □ No □

Anemia .... Yes □ No □

History of Blood Transfusion .... Yes □ No □

History of Stroke or TIA .... Yes □ No □

Sinusitis .... Yes □ No □

Asthma .... Yes □ No □

Tuberculosis .... Yes □ No □

COPD .... Yes □ No □

Hepatitis, Type ___ .... Yes □ No □

Liver Problems .... Yes □ No □

Kidney Problems .... Yes □ No □

Bladder Problems .... Yes □ No □

Ulcers .... Yes □ No □

Do you uuse a CPAP machine? .... Yes □ No □

Epilepsy or other neurological disorder .... Yes □ No □

If other, what? ____

History of Head Trauma .... Yes □ No □

Frequent or Severe Headaches or Migraines .... Yes □ No □

Thyroid Concerns .... Yes □ No□

Diabetes, Type ____ HbA1c _____ .... Yes □ No □

Family History of Diabetes .... Yes □ No □

Excessive Thirst .... Yes □ No □

Dry Mouth .... Yes □ No □

Oral Herpes or Cold Sores .... Yes □ No □

HIV + or Acquired Immune Deficiency Syndrome Yes □ No □

Have you recieved an organ transplant .... Yes □ No □

Have you donated an organ for transplant .... Yes □ No □

Have you had cancer? .... Yes □ No □

If yes, what type? ____

If yes, medication/treatment: ______________________________

Have you taken Fosomax/Boniva/Actonel/Zometa? Yes □ No □

Depression or Anxiety .... Yes □ No □

Mental Disorder .... Yes □ No□

If yes, please describe:____________________________________

History of Alcohol Abuse.................................... Yes □ No □

Do you Smoke? .... Yes □ No□

If yes, how often?_________________________________

Do you use smokeless tobacoo?............................ Yes □ No□

Gallstones or Gallbladder Problems .... Yes ◻ No ◻	If yes, how often?___________________________________
Arthritis .... Yes ◻ No ◻	**Women:**
Back or Neck Pain .... Yes ◻ No ◻	Pregnant, Due date: _________________________ Yes ◻ No ◻
Osteoporosis .... Yes ◻ No ◻	Are you Nursing? ....Yes ◻ No◻
Osteopina .... Yes ◻ No ◻	Contraceptive or Other Hormones............................Yes ◻ No◻
History of Fainting .... Yes ◻ No ◻	**Men:**
History of Siezures .... Yes ◻ No ◻	Do you take medication for erectile dysfunction?......Yes ◻ No◻
Do you snore or been told you snore .... Yes ◻ No ◻	Do you have a history of prostate cancer? .... Yes ◻ No◻
Have you been diagnosed with sleep apnea .... Yes ◻ No ◻	Other medical Conditons: ________________________________
History of Atrial Fibrillation .... Yes ◻ No ◻	

Current Medications and Supplements:

____

Preferred Pharmacy**:** ____

Allergies & Symptoms: ____

Do any members of your family have or have thye had in the past:

◻ Dentures? _____________________ ◻ Periodontal Disease? _________________________________

Have you ever had any serious trouble assocatied with a previous dental experience? Please specify: ___________

____

Please list any other comments regarding your teeth, mouth, or dental history: ____________________________
____

Has there been an accident or medical event that may be the cause for you being here? If yes, please explain:
____

Patient Authorization:

_____ I authorize the release of my dental records from University Place Family & Cosmetic Dentistry and/or individuals in my dental care. I further authorize the release of records from any individual to University Place Family & Cosmetic Dentistry.

_____ I authorize insurance payments to be made directly to University Place Family & Cosmetic Dentistry. I understand I am responsible for any unpaid balance.

_____ I am aware that should I not provide adequate notice to change or cancel an appointment, I may be charged a fee. (7 calendar days for a surgical appointment and 2 business days for a cleaning appointment or restorative appointment.)

_____ I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPPA).

Notice of Privacy Practice-Acknowledgement.

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels you to do so. You may see your record or get more information about it by contacting us.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of th eNotice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications.

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment postcards sent through the mail, messages left with roommates/family remembers, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize University Place Family & Cosmetic Dentistry and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information.

By my signature below, I authorize University Place Family & Cosmetic Dentistry and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name: _____________________ Relationship to patient: ____________ Cell phone: __________________

Name: _____________________ Relationship to patient: ____________ Cell phone: __________________

- ☐ I do not authorize University Place Family & Cosmetic Dentistry to discuss treatment and financial information with anyone other than myself.

Patient's Signature: ____ Date: ______________