

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 Female Marital 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: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> 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: _____

New Medical History 2

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

Previous Dental Experience (New Patients Only)

How did you hear about our office?

Occupation

How would you rate the condition of your mouth?

- Excellent
 Good
 Fair
 Poor

Name of previous dentist

Approximate date of most recent dental x-rays

Approximate date of most recent dental cleaning

I usually see my dentist every:

- 3 months
 4 months
 6 months
 12 months
 Not Routinely

Dental History

How anxious are you of dental treatment?

- Not at all
 Slightly
 Moderately
 Severely

Have you ever had complications from past dental

Yes No

If yes

Have you had braces or orthodontic treatment?

Yes No

Do you grind or clench your teeth?

Yes No

Periodontal and Joint

Do your gums bleed while brushing or flossing?

Yes No

Have you ever had a "Deep Cleaning" or a scaling and root planing type cleaning before?

Yes No

Have you ever been told you have gum disease?

Yes No

Are your teeth sensitive to hot or cold liquids/foods?

Yes No

Are your teeth sensitive to sweet liquids/foods?

Yes No

Do you feel pain to any of your teeth?

Yes No

Have you had any head, neck, or jaw injuries?

Yes No

Have you ever experienced any of the following problems in your jaw?

Clicking Yes No

Pain (joint, ear, side of face) Yes No

Difficulty opening or closing Yes No

Locking open or closed Yes No

Difficulty chewing Yes No

Smile Characteristics

Is there anything about the appearance of your teeth you would like to change or have addressed?

- Whitening
 Straighten teeth
 Repair chips or cracks
 Gum recession

Any esthetic concerns not listed?

Yes No

If yes

Are you taking any medications, pills, or drugs? Yes No If yes _____

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major surgery? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

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

Are you on a special diet? Yes No

Women: Are you...
 Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

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

| | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No | | | |

Have you ever had any serious illness not listed? Yes No If yes _____

Are there any additional items you would like the dentist to know about that haven't been covered? Yes No If yes _____

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: _____

ESTATES DENTAL

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Country Estates Family Dental's *HIPAA Notice of Privacy Practices*.

I understand that Country Estates Family Dental's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Country Estates Family Dental revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Country Estates Family Dental *HIPAA Notice of Privacy Practices*, I may contact Country Estates Family Dental, 23676 San Vicente Rd, Ramona, CA 92065, 760-789-2882.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Country Estates Family Dental will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Country Estates Family Dental privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Country Estates Family Dental, noted above, for assistance.

| | |
|--------------------------------------|--|
| _____ | _____ |
| Patient Signature | Date |
| _____ | _____ |
| Signature of Personal Representative | Print Name of Personal Representative |
| | _____ |
| | Relationship of Personal Rep. to Patient |

FOR OFFICE USE ONLY

Country Estates Family Dental made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Country Estates Family Dental was unable to obtain a signed Acknowledgement for the following reason(s)

- Refusal to sign Acknowledgement on _____, 20____.
- Communication barriers prohibited us from obtaining a signed Acknowledgement
- An emergency situation prohibited us from obtaining a signed Acknowledgement
- Other (Describe): _____

| | | |
|---------------|----|------------|
| Date Received | By | Patient ID |
|---------------|----|------------|

Todd Brilliant