Howze Family Denistry

PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____ Sex: ○ Female ○ Male

Address: _____City: _____State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birthdate: _____ Social Security #: _____-_____-_____

E-mail: _____□ I would like to receive email correspondences

Employed by: _____Occupation: _____

Preferred Pharmacy: _____Pharmacy Phone: _____

Who may we thank for referring you? _____

Emergency Contact Person & Phone Number: _____

Date of last Dental Care: _____ Date of last dental X-Rays: _____

Reason for Today's Visit: _____

Are you experiencing any dental problems? _____

Responsible Party (if different from patient):

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____-_____-_____

Dental Insurance Information

Name of Insured: _____Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____Member ID: _____Group #: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____Insurance Company: _____

Address: _____City: _____State: _____ Zip: _____

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 physicians care now? (PCP, Specialist…ECT) Yes ☐ No ☐

If YES, please list:

Have you ever been hospitalized/ had a major operation in the last 2 years? Yes ☐ No ☐

If YES, please list:

Have you ever had a serious head or neck injury? Yes ☐ No ☐

If YES, please list:

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

If YES, please list:

Do you have any allergies? Yes ☐ No ☐

If YES, please list:

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

If YES, please list:

Are you on blood thinners? Yes ☐ No ☐

If YES, please list:

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

If YES, please list:

Do you currently have any of the following?

AIDS/ HIV positive	Yes ☐ No ☐	ADHD	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐	Radiation treatments	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Hepatitis A	Yes ☐ No ☐	Hepatitis B or C	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Angina	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Arthritis/ Gout	Yes ☐ No ☐
Epilepsy or Seizures	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	Artificial Heart Valve	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Sinus trouble	Yes ☐ No ☐	Blood Disease	Yes ☐ No ☐
Kidney Problems	Yes ☐ No ☐	Breathing Problems	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Low Blood Pressure	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Chest Pains	Yes ☐ No ☐	Heart Attack/Failure	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Cold Sores/Fever Blister	Yes ☐ No ☐	Congenital Heart Disorder	Yes ☐ No ☐	Heart Pacemaker	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐	Heart trouble/ Disease	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐	Pregnant/ Nursing	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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Print Name:_____Signature:_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third- party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its *Notice of Privacy Practices* and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request restrictions on how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also, understand the restrictions my be denied, but if agreed upon the operation is bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

Signature:

Date:
