Please print out and complete the registration, medical history and HIPAA forms and bring them to our office.

Date _____

Last name (Mr. Mrs. Miss Ms Dr. Rev.)_____(First name)_____

Street Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Cell phone_____

Birthday _____ Age _____ Sex M F Who is your referring dentist? _____

In case of an emergency, who should we notify?_____ Their phone# _____

Will you permit our office to leave a message regarding your dental treatment on your voice mail? YES / NO

Dental History:

Have you had gum surgery? Yes / No When _____

Have you had scaling and root planing (deep cleaning) Yes / No When _____

Do you now have or have you ever experienced pain or discomfort in you jaw joint (TMJ)? YES / NO

Do you have headaches often? yes / no

Do you wake up with sore jaw muscles or do you have sore jaw muscles during the day ? YES / NO

Do you think you grind your teeth? (grinding is done mostly during sleep) yes / no

Do you smoke cigarettes? YES / NO If so, how many packs a day? _____

DENTAL INSURANCE:

Subscriber's Name: _____ Name of Insurance:_____

Subscriber's Birth date:_____ Subscriber's I.D. # _____-_____-_____ Employer: _____

Second insurance (if any):

Subscriber's Name: _____ Name of Insurance:_____

Subscriber's Birth date:_____ Subscriber's I.D. # _____-_____-_____ Employer: _____

Please read the following and sign: **I authorize the office to release any information relating to my diagnosis and treatment to the dental insurance companies or to any other doctor who may be involved in my treatment or care. I also authorize direct payment by my insurance to the doctor treating me (unless other arrangements have been made).**

Patient's signature **X** _____ Date: _____

MEDICAL HISTORY Please mark Yes (Y) or No (N) and if yes, please **circle the condition** you have or had in the past

Yes No Do you have to take antibiotics before your dental treatments?

Y N Anemia / Radiation treatment
Y N Drug / Alcohol abuse
Y N Diabetes / Tuberculosis
Y N Cancer / Chemotherapy
Y N Difficulty in breathing
Y N Emphysema / Glaucoma
Y N Hemophilia / Endocarditis
Y N Heart surgery / Mitral Valve Prolapse
Y N High / Low Blood pressure
Y N Sinus Problems / Kidney problems
Y N Circulatory problems / Blood disease
Y N Ulcers / Colitis
Y N Adverse reaction to dental anesthetics
Y N Asthma If yes, are the asthma attacks severe? _____ Do you use an inhaler? _____
Y N Allergies – if yes please list them _____

Y N Artificial bones or joints
Y N Abnormal bleeding / Arthritis
Y N Artificial Heart Valve
Y N Congenital Heart Defects
Y N Heart Attack / Stroke
Y N Epilepsy / Seizures / Fainting
Y N Heart Murmur/ Pacemaker
Y N Nervous / Psychiatric problems
Y N Liver disease / Hepatitis (A, B, C, other)
Y N Frequent Headaches
Y N Rheumatic heart disease
Y N HIV / AIDS

Do you now have or have you had any medical condition that requires antibiotic pre-medication prior to dental treatment? Yes / No If yes, please explain: _____

Have you had any intravenous treatment for osteoporosis or cancer? Yes / No If yes please explain:_____

Do you have or had any conditions not listed above? _____

Please list any medications you are taking _____

_____

Are you under the care of a physician? Yes No If yes, for what? _____

(WOMEN) Do you suspect of being pregnant? Yes No Are you nursing? Yes No If you are taking birth control pills, please be advised that certain medications may inhibit the action of birth control pills and other methods may need to be taken while taking medications.

Is there anything else we should know about your medical history ?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. I understand that if any changes occur in my medical/health condition in the future, I will inform this office prior to any dental treatment I receive. will not hold the dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's signature **X**_____ Date _____

----------Patients please do not write below this line----------

Doctor's notes:_____

_____

Medical History Update:

Has there been any change in your medical condition since you were here last? Yes__ No__ If yes, please explain: _____

_____

Please list any new medications you are taking:_____

Today's date: _____ Patient's signature _____

Medical History Update:

Has there been any change in your medical condition since you were here last? Yes__ No__ If yes, please explain: _____

_____

Please list any new medications you are taking:_____

Today's date: _____ Patient's signature _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH**INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security Number: _____

Address: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. To read the *"Notice of Privacy Practices"* please go to the menu at the top of this page under "**PATIENT INFORMATION**". Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____