#### **PATIENT REGISTRATION**

ID:	Chart ID:				
First Name:		Last Nar	ne:		Middle Initial:
Patient Is: Policy Hol		Preferred Nan	ne:		
	neone other than the patient)	l ast Na	me:		Middle Initial:
Birth Date:					
Patient Information	s also a Policy Holder for Patien	-	surance Policy Holder	O Secondary I	nsurance Policy Holder
	Work Phone:				
-	_				
Sex: Male	Female	0	Married O Sing	C	Separated Widowed
	Age				
E-mail:			I would like to receive	e correspondences via	a e-mail.
Employment Status: (				Section 3	erred By:
	) Full Time O Part Time	<ul> <li>Retired</li> </ul>			Dentist:
Student Status: O Fu	Il Time OPart Time				Contact:
Medicaid ID:	Pref. Denti	st:		Emergency C	ontact #:
Employer ID:	Pref. Pharr	nacy:			
Carrier ID:	Pref. Hyg.:				
Primary Insurance Inform	nation				
Name of Insured:			Relationship to	Insured: Self	) Spouse () Child () Other
Insured Soc. Sec:		Insured Birth Dat	te:		
Employer:			Ins. Company:		
Address 2:					
	.00 Rem. Deduct:		.00		
Secondary Insurance Inf					
Name of Insured:			Relationship to	Insured: Self	) Spouse () Child () Other
			e:		
Rem. Benefits:	.00 Rem. Deduct:		.00		

#### **MEDICAL HISTORY**

PATIENT NAME	Birth 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.

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:	Are you under a physician's care now?				Yes	No	If ves, please explain:					
Have you ever had a serious head or neck injury? Yes No If yes, please explain:												
Are you taking any medications, pills, or drugs?       Yes       No         Do you take, or have you taken, Phen-Fen or Redux?       Yes       No         Do you use tobacco?       Yes       No         More you allergic to any of the following?       No       Taking oral contraceptives?       Yes       No         Are you allergic to any of the following?       Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics         Other If yes, please explain:       Do you have, or have you had, any of the following?       AllShift/ Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renai Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renai Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renai Dialysis       Yes       No         A												
Do you take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special dief? Yes No Do you use tobacco? Yes No To you use outrolled substances? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? Alphania Yes No Diabetes Yes No Anemia Yes No Diabetes Yes No Anemia Yes No Diabetes Yes No Anemia Yes No Emphysical Yes No Anemia Yes No Excessive Bleding Yes No Herpatitis A Yes No Returnation Yes No Antificial Heart Valve Yes No Excessive Bleding Yes No Antificial Heart Valve Astificial Heart Valve Astificial Heart Valve Yes No Frequent Hearts No Second Pressure Yes No Sickle Cell Disease Yes No Antificial Heart Valve Yes No Frequent Hearts Yes No Cancer Astificial Heart Valve Yes No Frequent Hearts Yes No Blood Disease Yes No Frequent Hearts Yes No Frequent Hearts Yes No Frequent Hearts Yes No Frequent Hearts Yes No Frequent Hearts Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Sickle Yes No Sickle Cell Disease Yes No Sickle Yes No Sickle Cell Disease Yes												
Are you on a special diet?       Yes       No         Do you use tobacco?       Yes       No         Do you use controlled substances?       Yes       No         Do you use controlled substances?       Yes       No         Moren: 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?       Are you allergic to any of the following?       Metal       Latex       Local Anesthetics         Other       flyes, please explain:       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renal Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renal Dialysis       Yes       No         Anaphylaxis       Yes       No       Cortisone Medicine       Yes       No       Hepatitis A       Yes       No       Renal Dialysis       Yes       No         Anaphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis A       Yes       No       Sinus Trouble       Yes       No         Angina       Yes <td colspan="3"></td> <td></td> <td></td> <td>ir yes, piease explain:</td> <td></td> <td></td> <td></td> <td></td> <td></td>						ir yes, piease explain:						
Do you use tobacco?       Yes       No         Do you use controlled substances?       Yes       No         Do you need to pre-medicate?       Yes       No         Momen: 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       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:	Do you take, or	have you	i taken	Phen-Fen or Redux?	Yes	No						
Do you use controlled substances?       Yes       No       Mo       If yes, please explain:         Women: Are you Pregnant/Trying to get pregnant?       Yes       No       Taking oral contraceptives?       Yes       No       Nursing? Yes       No         Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:			Are y	ou on a special diet?	Yes	No						
Do you need to pre-medicate?       Yes       No       If yes, please explain:         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       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:			Ľ	)o you use tobacco?	Yes	No						
Do you need to pre-medicate?       Yes       No       If yes, please explain:         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       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:		Do you	use co	ntrolled substances?	Yes	No						
Are you allergic to any of the following?         Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:		Do	you ne	eed to pre-medicate?	Yes	No	If yes, please explain:					
Are you allergic to any of the following?         Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:	Women: Are you Pre	anant/Tr	vina to	aet pregnant? Ves		No	Taking oral contracer	ntives?	Voc	No Nursina?	Vec	No
Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics         Other       If yes, please explain:       Do you have, or have you had, any of the following?       No       Renal Dialysis       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renal Dialysis       Yes       No         AlDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renal Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Renal Dialysis       Yes       No         Anaphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Scalet Fever       Yes       No         Angina       Yes       No       Epilepsy or Seizures       Yes       No       Hives or Rash       Yes       No       Sindle Cell Disease       Yes       No         Antificial Heart Vaive       Yes       No       Excessive Thirst       Yes       No       Kidney Problemi       Yes       No       Sinus Trouble       <	•	-		• • •		NU		Juves:	163	NO NUISIIIg:	163	NO
Other       If yes, please explain:         Do you have, or have you had, any of the following?         AIDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Henophilia       Yes       No       Renal Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Drug Addiction       Yes       No       Hepatitis A       Yes       No       Rheumatic Fever       Yes       No         Anaphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis Bor C       Yes       No       Scarlet Fever       Yes       No         Angina       Yes       No       Excessive Steering       Yes       No       Hives or Rash       Yes       No       Sinus Trouble       Yes       No         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Irregular Heartbeat       Yes       No       Stocke       Yes       No         Blood Transfusion       Yes       No       Frequent Diarthea       Yes       No       Leukemia       Yes       No       Stocke       Yes       No         Blood Transfusion       Yes       No       Frequent Diarthea       Yes       No <td< th=""><th></th><th>-</th><th>ollowin</th><th>-</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></td<>		-	ollowin	-								
Do you have, or have you had, any of the following?         AIDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Renal Dialysis       Yes       No         Alzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Rheumatic Fever       Yes       No         Anaphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Rheumatism       Yes       No         Anemia       Yes       No       Easily Winded       Yes       No       Heip Blood Pressure       Yes       No       Shingles       Yes       No         Angina       Yes       No       Explespsy or Seizures       Yes       No       High Blood Pressure       Yes       No       Shingles       Yes       No         Artificial Heart Vaive       Yes       No       Excessive Bleeding       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes       No         Artificial Joint       Yes       No       Fraquent Cough       Yes       No       Liver Disease       Yes       No       Stroke<	Aspirin F	Penicillin		Codeine Ao	crylic		Metal Latex		Local	Anesthetics		
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRenal DialysisYesNoAlzbeimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRheumatic FeverYesNoAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRheumatismYesNoAnemiaYesNoEasily WindedYesNoHepatitis B or CYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHepatitis B or CYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoScickle Cell DiseaseYesNoArtfricial JointYesNoExcessive BleedingYesNoHives or RashYesNoScickle Cell DiseaseYesNoArtfricial JointYesNoExcessive ThirstYesNoHives or RashYesNoStomach/Intestinal DiseaseYesNoBlood TransfusionYesNoFrequent CoughYesNoKidney ProblemsYesNoStorkeYesNoBruate EasilyYesNoFrequent HeadachesYesNoLow Blood PressureYesNoTuberculosisYesNoCancerYesNoGanital HerpesYesNoLow Bloease	Other If yes, plea	ase expla	ain:									
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRenal DialysisYesNoAlzbeimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRheumatic FeverYesNoAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRheumatismYesNoAnemiaYesNoEasily WindedYesNoHepatitis B or CYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHepatitis B or CYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoScickle Cell DiseaseYesNoArtfricial JointYesNoExcessive BleedingYesNoHives or RashYesNoScickle Cell DiseaseYesNoArtfricial JointYesNoExcessive ThirstYesNoHives or RashYesNoStomach/Intestinal DiseaseYesNoBlood TransfusionYesNoFrequent CoughYesNoKidney ProblemsYesNoStorkeYesNoBruate EasilyYesNoFrequent HeadachesYesNoLow Blood PressureYesNoTuberculosisYesNoCancerYesNoGanital HerpesYesNoLow Bloease	Do you have or have	you had	any of	the following?								
Alzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Rheumatic Fever       Yes       No         Anaphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Rheumatism       Yes       No         Angina       Yes       No       Easily Winded       Yes       No       Herpes       Yes       No       Shingles       Yes       No         Angina       Yes       No       Epilepsy or Seizures       Yes       No       Hites or Rash       Yes       No       Sinugles       Yes       No         Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       Hirdesidal Yes       No       Sinus Trouble       Yes       No         Artificial Joint       Yes       No       Fraquent Cough       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes       No         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Liver Disease       Yes       No       Thyroid Disease       Yes       No       Enating Problem       Yes       No </td <td></td> <td></td> <td></td> <td>•</td> <td>Vee</td> <td>NI-</td> <td>11</td> <td>N</td> <td>NIE</td> <td>Danal Dishusia</td> <td>¥</td> <td>N</td>				•	Vee	NI-	11	N	NIE	Danal Dishusia	¥	N
AnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRheumatismYesNoAnemiaYesNoEasily WindedYesNoHerpesYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoShinglesYesNoArthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoSinglesYesNoArthritis/GoutYesNoExcessive BleedingYesNoHypoglycemiaYesNoSinus TroubleYesNoArtificial JointYesNoExcessive ThirstYesNoKidney ProblemsYesNoStomach/Intestinal DiseaseYesNoBlood DiseaseYesNoFrequent CoughYesNoLiver DiseaseYesNoStorkeYesNoBlood TransfusionYesNoFrequent DiarrheaYesNoLow Blood PressureYesNoThyroid DiseaseYesNoBruise EasilyYesNoGenital HerpesYesNoLow Blood PressureYesNoTuberculosisYesNoCancerYesNoGenital HerpesYesNoLiver DiseaseYesNoTuberculosisYesNoCherto HerapyYesNoGenital HerpesYesNoMitral Valve ProlapseYes												
AnemiaYesNoEasily WindedYesNoHerpesYesNoScarlet FeverYesNoAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoShinglesYesNoArthritis/GoutYesNoEpilepsy or SeizuresYesNoHives or RashYesNoSickle Cell DiseaseYesNoArthritis/Heart ValveYesNoExcessive BleedingYesNoHives or RashYesNoSinus TroubleYesNoArtificial JointYesNoExcessive ThirstYesNoHives or RashYesNoSinus TroubleYesNoAstmaYesNoFainting Spells/DizzinessYesNoKidney ProblemsYesNoStorach/Intestinal DiseaseYesNoBlood DiseaseYesNoFrequent CoughYesNoLeukemiaYesNoStorkeYesNoBlood TransfusionYesNoFrequent HeadachesYesNoLow Blood PressureYesNoThyroid DiseaseYesNoBruise EasilyYesNoGenital HerpesYesNoLung DiseaseYesNoTuberculosisYesNoCancerYesNoGlaucomaYesNoLing DiseaseYesNoTuberculosisYesNoChest PainsYesNoHay FeverYesNoPain in Jaw JointsYes <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>												
AnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoShinglesYesNoArthificial Heart ValveYesNoExcessive BleedingYesNoHives or RashYesNoSickle Cell DiseaseYesNoArtificial Heart ValveYesNoExcessive BleedingYesNoHypoglycemiaYesNoSickle Cell DiseaseYesNoArtificial JointYesNoExcessive ThirstYesNoHypoglycemiaYesNoSpinas BifdaYesNoAsthmaYesNoFrequent CoughYesNoKidney ProblemsYesNoStomach/Intestinal DiseaseYesNoBlood DiseaseYesNoFrequent CoughYesNoLeukemiaYesNoStorkeYesNoBlood TransfusionYesNoFrequent DiarrheaYesNoLow Blood PressureYesNoSwelling of LimbsYesNoBreathing ProblemYesNoGenital HerpesYesNoLung DiseaseYesNoTumors or GrowthsYesNoCancerYesNoGlaucomaYesNoParathyroid DiseaseYesNoTumors or GrowthsYesNoChest PainsYesNoHeart Attack/FailureYesNoParathyroid DiseaseYesNoTumors or GrowthsYesNoConcerYesNoHeart MurmurYes <td< td=""><td></td><td></td><td></td><td>•</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>				•								
Arthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No       Hives or Rash       Yes       No       Sickle Cell Disease       Yes       No         Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       Hives or Rash       Yes       No       Sinus Trouble       Yes       No         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Firegular Heartbeat       Yes       No       Spina Bifida       Yes       No         Astima       Yes       No       Fainting Spells/Dizziness       Yes       No       Leukemia       Yes       No       Storach/Intestinal Disease       Yes       No         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Storach/Intestinal Disease       Yes       No         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Storach/Intestinal Disease       Yes       No         Blood Disease       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes				-								
Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       Hypoglycemia       Yes       No       Sinus Trouble       Yes       No         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Irregular Heartbeat       Yes       No       Spina Bifida       Yes       No         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Kidney Problems       Yes       No       Stomach/Intestinal Disease       Yes       No         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Storach/Intestinal Disease       Yes       No         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Thyroid Disease       Yes       No         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Tuberculosis       Yes       No         Cancer       Yes       No       Haart Attack/Failure       Yes       No       Pain in Jaw Joints       Yes       No       Tuberculosis       Yes       No	-						0			•		
Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Irregular Heartbeat       Yes       No       Spina Bifida       Yes       No         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Kidney Problems       Yes       No       Stomach/Intestinal Disease       Yes       No         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes       No         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stroke       Yes       No         Breathing Problem       Yes       No       Frequent Headaches       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       No         Gancer       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         Chemotherapy       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No												
AsthmaYesNoFainting Spells/DizzinessYesNoKidney ProblemsYesNoStomach/Intestinal DiseaseYesNoBlood DiseaseYesNoFrequent CoughYesNoLeukemiaYesNoStrokeYesNoBlood TransfusionYesNoFrequent DiarrheaYesNoLiver DiseaseYesNoStrokeYesNoBreathing ProblemYesNoGenital HerpesYesNoLow Blood PressureYesNoThyroid DiseaseYesNoBruise EasilyYesNoGenital HerpesYesNoLung DiseaseYesNoTonsillitisYesNoCancerYesNoGlaucomaYesNoMitral Valve ProlapseYesNoTuberculosisYesNoChemotherapyYesNoHeart Attack/FailureYesNoPain in Jaw JointsYesNoUlcersYesNoCold Sores/Fever BlistersYesNoHeart MurmurYesNoRediation TreatmentsYesNoYellow JaundiceYesNoCongenital Heart DisorderYesNoHeart Trouble/DiseaseYesNoRediation TreatmentsYesNoYellow JaundiceYesNoConvulsionsYesNoHeart Trouble/DiseaseYesNoRecent Weight LossYesNoYellow JaundiceYesNoHave you ever had any serious illness not listed above? <td></td> <td></td> <td></td> <td>•</td> <td></td> <td></td> <td>51 05</td> <td></td> <td></td> <td></td> <td></td> <td></td>				•			51 05					
Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Stroke       Yes       No         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Liver Disease       Yes       No       Swelling of Limbs       Yes       No         Breathing Problem       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       No         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Tuberculosis       Yes       No         Cancer       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         Chemotherapy       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Tumors or Growths       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Radiation Treatments       Yes       No       Yes       No         Conoruulsions							U					
Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Liver Disease       Yes       No       Swelling of Limbs       Yes       No         Breathing Problem       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       No         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Tonsillitis       Yes       No         Cancer       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         Chemotherapy       Yes       No       Hay Fever       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Radiation Treatments       Yes       No       Yes       No         Congenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No         Have you ever had any serious illness not listed above?				• •								
Breathing Problem       Yes       No       Frequent Headaches       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       No         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Tonsillitis       Yes       No         Cancer       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         Chemotherapy       Yes       No       Hay Fever       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Radiation Treatments       Yes       No       Yes       No         Convulsions       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No         Have you ever had any serious illness not listed above?       Yes												
Bruise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Tonsillitis       Yes       No         Cancer       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         Chemotherapy       Yes       No       Hay Fever       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Radiation Treatments       Yes       No       Yes       No         Convulsions       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No       Yes       No         Have you ever had any serious illness not listed above?       Yes       No       If yes, please explain:				•						-		
CancerYesNoGlaucomaYesNoMitral Valve ProlapseYesNoTuberculosisYesNoChemotherapyYesNoHay FeverYesNoPain in Jaw JointsYesNoTumors or GrowthsYesNoChest PainsYesNoHeart Attack/FailureYesNoParathyroid DiseaseYesNoUlcersYesNoCold Sores/Fever BlistersYesNoHeart MurmurYesNoPsychiatric CareYesNoVenereal DiseaseYesNoCongenital Heart DisorderYesNoHeart Pace MakerYesNoRadiation TreatmentsYesNoYellow JaundiceYesNoConvulsionsYesNoHeart Trouble/DiseaseYesNoIf yes, please explain:	•									•		
Chemotherapy       Yes       No       Hay Fever       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Psychiatric Care       Yes       No       Venereal Disease       Yes       No         Congenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No       Yes       No         Have you ever had any serious illness not listed above?       Yes       No       If yes, please explain:	•						0					
Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Psychiatric Care       Yes       No       Venereal Disease       Yes       No         Congenital Heart Disorder       Yes       No       Heart Pace Maker       Yes       No       Radiation Treatments       Yes       No       Yellow Jaundice       Yes       No         Convulsions       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No         Have you ever had any serious illness not listed above?       Yes       No       If yes, please explain:												
Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Psychiatric Care       Yes       No       Venereal Disease       Yes       No         Congenital Heart Disorder       Yes       No       Heart Pace Maker       Yes       No       Radiation Treatments       Yes       No       Yellow Jaundice       Yes       No         Convulsions       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No         Have you ever had any serious illness not listed above?       Yes       No       If yes, please explain:												
Congenital Heart Disorder       Yes       No       Heart Pace Maker       Yes       No       Radiation Treatments       Yes       No       Yellow Jaundice       Yes       No         Convulsions       Yes       No       Heart Trouble/Disease       Yes       No       Recent Weight Loss       Yes       No         Have you ever had any serious illness not listed above?       Yes       No       If yes, please explain:							•					
Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Have you ever had any serious illness not listed above? Yes No If yes, please explain:							•					
Have you ever had any serious illness not listed above? Yes No If yes, please explain:	0									Yellow Jaundice	Yes	No
	Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			
Comments:	Have you ever had an	y serious	illness	s not listed above?	Yes	No	If yes, please explain	:				
Comments												
Comments:	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 \_\_\_\_\_\_



# **Dismissal Agreement**

I **understand** that it is my responsibility to provide a 48 hour notice to cancel or change an appointment. I **understand** that this gives Blackman Grove Dental ample time to fill my appointment. I **understand** that if I am unable to give this notice I will be considered a NO SHOW. I **understand** that after 2 NO SHOW appointments I will be dismissed from the practice.



### **Financial Statement**

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and / or attorney fees.

### **Insurance Statement**

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

## Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have seen a copy of Privacy Practices Policy located in the lobby. I have also declined a copy of the Practice Privacy Policy.

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Signature of Patient or Responsible Party

# **Blackman Grove Dental**

Dental Treatment Consent

PATIENT NAME (please print) \_\_\_\_\_\_ DATE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby give consent and authorize the dentist and/or team member of Blackman Grove Dental to take any x-rays, study models, intra-oral photos or any other aids deemed appropriate to make a thorough diagnosis of my dental needs. I also give consent and authorize the dentist to perform any and all recommended forms of treatment mutually agreed upon by the doctor and myself. I consent to the use of the appropriate topical medications, anesthetics and therapy that may be indicated in my treatment. I understand that there may be certain risk when using local anesthetic agents or nitrous oxide if needed. Furthermore, I consent and authorize that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment.

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#### PATIENT AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

Description of specific information authorized:

Description of the specific purposes for use and disclosure:

Parties requesting information and authorized to use and disclose the information:

Parties to whom information may be disclosed:

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;
- Inspect or copy the protected health information to be used or disclosed;
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

I understand that information used or disclosed pursuant to this authorization may be subject to additional disclosure by the recipient and no longer protected by HIPAA.

You will receive compensation from a third party for the use or disclosure of my information: Yes or No

This authorization is effective from \_ day of \_\_\_\_, 20 \_\_\_until \_\_\_\_\_ day of \_\_\_\_, 20 \_\_\_.

Print Patient Name:		
Relationship (if other than patient):		
Signature:	17	ice

Practice Name:\_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip:\_\_\_\_\_

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