## *PATIENT REGISTRATION AND HEALTH HISTORY*

Patient's Name _____ Today's Date _____
Home
Address_____City_____St____Zip_____

Tel.#_____ Cell#_____ Email Address_____

Social Security#_____ Date of Birth _____ Age ____Marital Status_____

Employer_____ Work# _____How Long _____

Spouse's Name_____ Social Security#_____Date of Birth_____

Spouse's Employer_____ Spouse's Work#_____ Cell#_____

Person to Contact in Emergency_____ Contact #_____

***Financial***
**Person Responsible for Account_____Phone#_____**

Address_____City/State/Zip_____
Relationship to Patient_____

***Insurance Information***

Name of Insured_____ Relationship to Patient_____
Date of Birth_____ Social Security# _____ Ins ID# _____
Name of Employer_____ Work #_____
Address of Employer_____ City/State/Zip _____
Insurance Company_____ Group #_____Phone#_____
Ins Co. Address _____City/State/Zip _____
Is this Insurance your PRIMARY Insurance? Yes_____ No_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES____ NO_____
If yes, please complete the following:

Name of Insured_____ Relationship to Patient_____
Date of Birth _____ Social Security# _____ Ins ID#_____
Name of Employer_____ Work #_____
Address of Employer _____ City/State/Zip_____
Insurance Company _____ Group# _____ Phone#_____
Insurance Address _____ City/State/Zip _____

***Dental History***

Previous Dentist_____City/State_____
Date of last visit_____Date of last cleaning_____Date of last x-ray_____

***Health History***

1. List your current physician's name_____Office #_____
2. Are you aware of any changes in your general health in the last year? NO YES
3. Have you been hospitalized for illness or surgery in the past two years? NO YES
4. Have you been in the care of a physician during the past two years? NO YES
5. Have you ever had excessive bleeding that required special treatment? NO YES
6. Are you currently taking blood thinners? (including aspirin) NO YES
7. List all medications you are now taking (including over the counter)_____
_____
8. Are you allergic or have you reacted adversely to any of the following medications?

| | | | | |
|---|---|---|---|---|
| Aspirin | Nitrous Oxide | Valium | Local Anesthetic | Latex |
| Darvon | Erythromycin | Novocain or Xylocaine | | |
| Codeine | Tetracycline | Penicillin | Demerol | |
| Percodan | Sulfur | Other:_____ | | |

9. Circle any of the following, which you have had or have at present:

| | | |
|---|---|---|
| Heart Failure | Emphysema | A.I.D.S. |
| Heart Disease or Attack | Cough | Hepatitis A |
| Angina Pectoris | Tuberculosis(TB) | Hepatitis B |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Artificial Joints(Hip, Knee) | Scarlet Fever | Diabetes |
| Rheumatic Fever | Sinus Trouble | Blood Transfusion |
| Allergies or Hives | Drug Addiction | Artificial Heart Valve |
| Thyroid Disease | Heart Pacemaker | Epilepsy or Seizures |
| Heart Surgery | Fainting or Dizzy Spells | Anemia |
| Stroke | Kidney Trouble | Psychiatric Treatment |
| Mitral Valve Prolapse | | |

10. Do you have any other medical condition not listed?_____

11. For Women Only:
Are you pregnant? _____YES _____NO If yes, what month? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor before my next visit.

Patient
Signature_____Date_____

# PATIENT CONSENT FORM

I understand that, under the 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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment form third party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restricted restrictions, but if you do not agree then you are bound to abide to such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Patient Name**_____

**Signature**_____

**Relationship to Patient**_____

**Date**_____