ph. 208.356.9262

Patient Registration

Patient Information:

Name: ______ Birthdate: ______ Social Security #: ______

Address: ______ City: ______ Zip Code: ______

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: ______ Occupation: ______ Work Phone: ______

Home Phone: ______ Cell Phone: ______ Email: ______

Spouse: ______ Birthdate: ______ Social Security #: ______

Employer: ______ Occupation: ______

Work Phone: ______ Cell Phone: ______ Email: ______

If Patient is a minor, please complete the following:

Name of person responsible for this account: ______ Relationship to Patient: ______

Address: ______ City: ______ Zip Code: ______

Cell Phone: ______ Birthdate: ______ Social Security #: ______

Employer: ______ Occupation: ______ Work Phone: ______

General Information:

General Dentist: ______ City: ______ Orthodontist: ______ City: ______

Other people involved in dental care: ______

General Physician: ______ City: ______ Emergency Contact: ______ Phone: ______

Dental Insurance Information:

Primary Insurance Company: ______

Policy Holder: ______ DOB: ______

Patient's Relationship to Policy Holder: ______

Social Security # OR ID #: ______

Secondary Insurance Company: ______

Policy Holder: ______ DOB: ______

Patient's Relationship to Policy Holder: ______

Social Security # OR ID #: ______

Medical Insurance Information:

Primary Insurance Company: ______

Policy Holder: ______ DOB: ______

Patient's Relationship to Policy Holder: ______

Social Security # OR ID #: ______

Secondary Insurance Company: ______

Policy Holder: ______ DOB: ______

Patient's Relationship to Policy Holder: ______

Social Security # OR ID #: ______

We would like to introduce you to our Patient Connect Program

Patient Connect is a way that we can make it easier for you to remember your appointment by sending you reminders via text message or email. Its benefits include being able to read the messages at your convenience without the interruption of a phone call. You are also able to confirm your appointment electronically. We understand your time is valuable and it's sometimes challenging to receive our calls. Do you consent to receiving text or email reminders? We will utilize the contact information provided above.

☐ YES ☐ NO

Dental Health Center ph. 208.356.9262

Medical & Dental History Questionnaire

Patient Name: ______________________ Date: ______________

Current Medications & Supplements: ______________________

____

Preferred Pharmacy: ______________
Allergies & Symptoms: ______________________

____

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Do you have or have you had any of the following:

Heart Problems	YES	NO
If yes, please describe: ______________		
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
Pacemaker	YES	NO
Artificial Heart Valve	YES	NO
Joint Replacement	YES	NO
If yes, please describe: ______________		
Is an antibiotic premed required before treatment?	YES	NO
If so, what type/dosage? ______________		
Easy Bruising	YES	NO
Abnormal Bleeding	YES	NO
Frequent Nose Bleeds	YES	NO
Anemia	YES	NO
History of Blood Transfusion	YES	NO
History of Stroke or TIA	YES	NO
Sinusitis	YES	NO
Asthma	YES	NO
Tuberculosis	YES	NO
COPD	YES	NO
Hepatitis, Type:	YES	NO
Liver Problems	YES	NO
Kidney Problems	YES	NO
Bladder Problems	YES	NO
Ulcers	YES	NO
Gallstones or Gallbladder Problems	YES	NO
Arthritis	YES	NO
Back or Neck Pain	YES	NO
Osteoporosis	YES	NO
Osteopenia	YES	NO
History of Fainting	YES	NO
History of Seizures	YES	NO

Epilepsy or other neurological disorder	YES	NO
If other, what? ______________		
History of Head Trauma	YES	NO
Frequent or Severe Headaches or Migraines	YES	NO
Thyroid Concerns	YES	NO
Diabetes, Type: ________ HbA1c: __________	YES	NO
Family History of Diabetes	YES	NO
Excessive Thirst	YES	NO
Dry Mouth	YES	NO
Oral Herpes or Cold Sores	YES	NO
HIV+ or Acquired Immune Deficiency Syndrome	YES	NO
Have you received an organ transplant?	YES	NO
Have you donated an organ for transplant?	YES	NO
Have you had cancer?	YES	NO
If yes, type:		
If yes, medication/treatment:		
Have you taken Fosamax/Boniva/Actonel/Zometa?	YES	NO
Depression or Anxiety	YES	NO
History of Alcohol Abuse	YES	NO
History of Drug Abuse	YES	NO
Do you smoke?	YES	NO
If yes, how often? ______________		
Do you use smokeless tobacco?	YES	NO
If yes, how often? ______________		
Women:		
Pregnant, Due Date: ______________	YES	NO
Are you nursing?	YES	NO
Contraceptives or Other Hormones	YES	NO
Men:		
Do you take medications for erectile dysfunction?	YES	NO
Do you have a history of prostate cancer?	YES	NO
Other Medical Condition: ______________		

Do you wish you slept better at night and had more energy? __________ Do you feel tired throughout the day? __________

Have you been told by others that you snore? ________ Has a C-PAP machine been prescribed for you before? __________

Do any members of your family have or have they had in the past (please indicate relationship to you):

☐ Dentures ______________ ☐ Periodontal Disease______________

Have you ever had any serious trouble associated with a previous dental experience? Please specify: ______________

____

Please list any other comments regarding your teeth, mouth, or dental history: ______________________

____

Has there been an accident or medical event that may be the cause for you being here? If yes, please explain: ______________

____

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Patient Authorizations

________ I authorize the release of my dental records from Dental Health Center and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Dental Health Center.

________ I authorize insurance payments to be made directly to Dental Health Center. I understand I am responsible for any unpaid balance.

________ I am aware that should I not provide adequate notice to change an appointment, I may be charged a fee. (7 calendar days for a surgical appointment ($300.00) and 2 business days for a cleaning appointment ($50.00).

________ I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice – Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize Dental Health Center and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Dental Health Center and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name: ______________________ Relationship to Patient: ______________ Cell Phone: ______________

Name: ______________________ Relationship to Patient: ______________ Cell Phone: ______________

☐ I do not authorize Dental Health Center to discuss treatment and financial information with anyone other than myself.

Patient's Signature: ____ Date: ______________