

Patient Registration

Dental Health Center 208-356-9262

Patient Information:

Name: _____ Birthdate _____ Social Security # _____

Address: _____ City and State: _____ Zip Code _____

Phone Number: _____ Employer: _____ Work Phone: _____

Gender: _____ Email: _____ Marital Status: _____

How did you hear about us? _____

Dental Insurance: _____ Policy Holder: _____

Policy Holder Address: _____ City and State: _____ Zip: _____

Phone: _____ Policy Holder Birthdate: _____ Employer: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder Address: _____ City and State: _____ Zip: _____

Phone: _____ Policy Holder Birthdate: _____ Employer: _____

Insurance ID #: _____ Group #: _____

Medical Insurance: _____ Policy Holder: _____

Policy Holder Address: _____ City and State: _____ Zip: _____

Phone: _____ Policy Holder Birthdate: _____ Employer: _____

Insurance ID #: _____ Group #: _____

Patient Connect is a way that we can make it easier for you to remember your appointments by sending you reminders via text message or email. You are also able to confirm your appointments electronically. Do you consent to receiving text or email reminders? YES NO

Dental Health Center
 Medical & Dental History Questionnaire

ph. 208.356.9262



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:			Epilepsy or other neurological disorder	YES	NO
Heart Problems	YES	NO	If other, what? _____		
If yes, please describe: _____			History of Head Trauma	YES	NO
High Blood Pressure	YES	NO	Frequent or Severe Headaches or Migraines	YES	NO
Low Blood Pressure	YES	NO	Thyroid Concerns	YES	NO
Pacemaker	YES	NO	Diabetes, Type: _____ HbA1c: _____	YES	NO
Artificial Heart Valve	YES	NO	Family History of Diabetes	YES	NO
Joint Replacement	YES	NO	Excessive Thirst	YES	NO
If yes, please describe: _____			Dry Mouth	YES	NO
Is an antibiotic premed required before treatment?	YES	NO	Oral Herpes or Cold Sores	YES	NO
If so, what type/dosage? _____			HIV+ or Acquired Immune Deficiency Syndrome	YES	NO
Easy Bruising	YES	NO	Have you received an organ transplant?	YES	NO
Abnormal Bleeding	YES	NO	Have you donated an organ for transplant?	YES	NO
Frequent Nose Bleeds	YES	NO	Have you had cancer?	YES	NO
Anemia	YES	NO	If yes, type:		
History of Blood Transfusion	YES	NO	If yes, medication/treatment:		
History of Stroke or TIA	YES	NO	Have you taken Fosamax/Boniva/Actonel/Zometa?	YES	NO
Sinusitis	YES	NO	Depression or Anxiety	YES	NO
Asthma	YES	NO	History of Alcohol Abuse	YES	NO
Tuberculosis	YES	NO	History of Drug Abuse	YES	NO
COPD	YES	NO	Do you smoke?	YES	NO
Hepatitis, Type:	YES	NO	If yes, how often? _____		
Liver Problems	YES	NO	Do you use smokeless tobacco?	YES	NO
Kidney Problems	YES	NO	If yes, how often? _____		
Bladder Problems	YES	NO	Women:		
Ulcers	YES	NO	Pregnant, Due Date: _____	YES	NO
Gallstones or Gallbladder Problems	YES	NO	Are you nursing?	YES	NO
Arthritis	YES	NO	Contraceptives or Other Hormones	YES	NO
Back or Neck Pain	YES	NO	Men:		
Osteoporosis	YES	NO	Do you take medications for erectile dysfunction?	YES	NO
Osteopenia	YES	NO	Do you have a history of prostate cancer?	YES	NO
History of Fainting	YES	NO	Other Medical Condition: _____		
History of Seizures	YES	NO	_____		

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: _____



_____ 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: _____