smilesofboca
RESTORATIVE & COSMETIC DENTISTRY

REGISTRATION

PATIENT INFORMATION

Patient's Name _____ Age _____ Date of Birth _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Minor

If Child, Parent's Name _____ How do you wish to be addressed _____
Purpose of today's visit _____
Whom may we thank for referring you? / How did you hear about us? _____

Address _____ City _____ State _____ Zip _____
Telephone _____ Cellphone _____ E-mail _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____

Patient's SS# (FOR INSURANCE PURPOSES) _____ Driver's License # _____
Spouse Name _____ Spouse/Parent SS# _____
Other family members in this practice _____
Someone to notify in case of emergency,not living with you _____ Telephone _____
Who is responsible for this account _____

Method of payment: ☐ Cash ☐ Check ☐ Credit Card

DENTAL INSURANCE

Principal's name _____ Date of Birth _____ Social Security # _____
Insurance Company _____ Subscriber ID# _____ Group Policy # _____
Address _____ Telephone _____

DENTAL HISTORY

Former Dentist _____ City, State _____
Date of Last Dental Visit _____ Date of Last X-Rays _____
How often do you Floss? _____ How often do you brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitiviy to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Tooth Pain ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding or Clenching Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Blisters, Sores, Lumps on Lips or Mouth ☐

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PRINT NAME _____

CONTINUE TO NEXT PAGE ➡

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MEDICAL HISTORY

PATIENT'S NAME: _____

CIRCLE THE APPROPRIATE ANSWER. USE THE COMMENTS BOX TO EXPAND/EXPLAIN YOUR ANSWERS AS NEEDED

1. Are you under a physician's care? ..... YES NO
2. Physician's Name _____
   Address _____
   _____ Tel: _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? (Please list) ..... YES NO
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ..... YES NO
6. Are you allergic to any medications or substances? (Please list) ..... YES NO
7. Do you have any other allergies or hives? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? (Please circle) ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? (Please circle) ..... YES NO
17. Have you ever been hospitalized, had a serious illness or major surgery? ..... YES NO
18. Have you ever had radiation treatment, chemo therapy for tumor, growth or cancer? ..... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ..... YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints/prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach or digestive problems? ..... YES NO
25. Do you have any kidney problems? ..... YES NO
26. Do you have any thyroid problems? ..... YES NO
27. Do you have any liver problems? ..... YES NO
28. Are you diabetic? ..... YES NO
29. Do you have fainting or dizzy spells? ..... YES NO
30. Do you have asthma? ..... YES NO
31. Do you have epilepsy or seizure disorders? ..... YES NO
32. Do you or have you had a venereal or sexually transmitted disease (STD)? ..... YES NO
33. Have you tested HIV positive? ..... YES NO
34. Do you have AIDS? ..... YES NO
35. Have you had or do you test positive for hepatitis? If so, what type? ..... YES NO
36. Do you or have you had Tuberculosis (TB)? ..... YES NO
37. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
38. Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO
39. Do you habitually use controlled substances (cannabis, cocaine, etc)? ..... YES NO
40. Have you had psychiatric treatment? ..... YES NO
41. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (Fen-phen), dexfenfluramine (Redux), or other weight loss products? ..... YES NO
42. Do you have any disease, condition, or problem not listed? If so, explain ..... YES NO
    _____
43. Is there anything else we should know about your health that was not covered in this form? ..... YES NO
    _____
44. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

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CONSENT TO PRIVACY PRACTICES (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize this office to disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other helathcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. dental insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that ocurred prior to the date I revoke this consent is not affected.

Signed this_____ day of _____ , 20 ____

Print name:_____

Relationship to Patient:_____

Signature: _____

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