SEBRING FAMILY DENTISTRY

PATIENT REGISTRATION

Date: _____

Name: (please print) _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact Phone No.: _____ Secondary Contact Phone No.: _____

Date of Birth: _____ SSN# _____ DL#: _____

Male
Female
Married
Single
Divorced
Widowed

Primary Insurance: _____

Group Number: _____ Employer: _____

Policy Number: _____ Subscriber: _____

Relationship to Patient: _____

Secondary Insurance: _____

Group Number: _____ Employer: _____

Policy Number: _____ Subscriber: _____

Emergency Contact: _____ Phone Number: _____

Relative or Family Member a patient here? Y / N Name: _____

How did you hear about us? _____

Financial Responsibility (if not the patient):

Name: _____ Phone No.: _____ Relationship: _____

Address: _____ SSN#: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due prior to services being rendered.

Patient/Responsible Party's Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____

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Patient HIPAA Consent Form

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 I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our 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 health care 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 occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Patient Name	**MEDICAL HISTORY**
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Latex Sensitivity	Yes	No
Heart Murmur	Yes	No	Allergies or Hives	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No
Artificial Heart Valve	Yes	No	Chemotherapy	Yes	No
Heart Pacemaker	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Arthritis/Rheumatism	Yes	No	Venereal Disease	Yes	No
Cortisone Medicine	Yes	No	A.I.D.S.	Yes	No
Swollen Ankles	Yes	No	H.I.V. Positive	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No
Diet (Special/ Restricted)	Yes	No	Blood Transfusion	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Hemophilia	Yes	No
Kidney Trouble	Yes	No	Sickle Cell Disease	Yes	No
Ulcers	Yes	No	Bruise Easily	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Problems	Yes	No	Yellow Jaundice	Yes	No
Glaucoma	Yes	No	Neurological Disorders	Yes	No
Contact lenses	Yes	No	Epilepsy or Seizures	Yes	No
Emphysema	Yes	No	Fainting or Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous/Anxious	Yes	No
Tuberculosis	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No
   If yes, please list: _____
10. **Women**: Are you: **Pregnant?** Yes _____ Months No **Nursing?** Yes No **Taking Birth Control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

DENTAL HISTORY

Patient Name

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** What was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

Do you have any dental problems now? _____

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	Yes	No

_____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

_____

_____