# PATIENT REGISTRATION

**Patient Information:**

First Name: ______________________________ Last Name: ______________________________

Address: ________________________________________________________________________

City, State, Zip Code: ______________________________________________________________

Cell Phone: ____________________________ Work Phone: ____________________________

Alternate Phone: ____________________________ Email: ___________________________________

Ok to receive email correspondence? (Appt reminders, etc): YES / NO

How did you hear about ALLHEART DENTAL? ____________________________________________

Social Security: _________________________ D.O.B: _______________ DL#: ________________

Emergency Contact: ___________________________________ Phone: _________________________

Sex: M or F Marital Status: Single Married Divorced Separated Widowed Partnered

Primary Insurance Information:

Name of Insured: ______________________________ Relationship to Patient: __________________

Insured's Employer: _____________________________ Employer Phone: _______________________

Insurance Company: ____________________________ Insurance Phone: _______________________

**Please carefully read below:**

I THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE ALLHEART DENTAL TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND ALLHEART DENTAL, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO ALLHEART DENTAL AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

_______________________________________ ________________________

Patient Signature Date

## MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain ___________________________________________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain ___________________________________________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain ___________________________________________________

Are you taking any medications, pills or drugs? Yes No If yes, please explain ___________________________________________________

Do you take or have you taken Phen-Fen or Redux? Yes No ______________________________________________________________________

Are you on a special diet? Yes No ______________________________________________________________________

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

**Women:**

Taking oral contraceptives? Yes No

Pregnant/Trying to get pregnant? Yes No

Nursing? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

**Are you allergic to any of the following?**

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other ____________________________________________________________________________________________________

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive | Cortisone Medicine | Hemophilia | Radiation Treatments |
| Alzheimer's disease | Diabetes | Hepatitis A | Recent Weight Loss |
| Anaphylaxis | Drug Addiction | Hepatitis B or C | Renal Dialysis |
| Anemia | Easily Winded | Herpes | Rheumatic Fever |
| Angina | Emphysema | High Blood Pressure | Rheumatism |
| Arthritis/Gout | Epilepsy or Seizures | High Cholesterol | Scarlet Fever |
| Artificial Heart Valve | Excessive Bleeding | Hives or Rash | Shingles |
| Artificial Joint | Excessive Thirst | Hypoglycemia | Sickle Cell Disease |
| Asthma | Fainting Spells/Dizziness | Irregular Heartbeat | Sinus Trouble |
| Blood Disease | Frequent Cough | Kidney Problems | Spina Bifida |
| Blood Transfusion | Frequent Diarrhea | Leukemia | Stomach/Intestinal Disease |
| Breathing Problem | Frequent Headaches | Liver Disease | Stroke |
| Bruise Easily | Genital Herpes | Low Blood Pressure | Swelling of Limbs |
| Cancer | Glaucoma | Lung Disease | Thyroid Disease |
| Chemotherapy | Hay Fever | Mitral Valve Prolapse | Tonsillitis |
| Chest Pains | Heart Attack/Failure | Osteoporosis | Tuberculosis |
| Cold Sores/Fever Blisters | Heart Murmur | Pain in Jaw Joints | Tumors or Growths |
| Congenital Heart Disorder | Heart Pacemaker | Parathyroid Disease | Ulcers |
| Convulsions | Heart Trouble/Disease | Psychiatric Disease | Venereal Disease |
| | | | Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain ___________________________________________

Additional Comments ____________________________________________________________________________________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATUR E OF PATIENT, PARENT OR GUARDIAN ____________________________________________ DATE ________________________