Theil & Theil
D.D.S.
General Dentistry

PATIENT REGISTRATION FORM

Patient Name: _____

Preferred Name: (If different than above): _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Sex at Birth: ☐ Male ☐ Female

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: ____ Zip: _____

Email Address: _____

Patient referred by: _____

RESPONSIBLE PARTY INFORMATION (If different than patient)

Name: _____

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: ____ Zip: _____

Email Address: _____

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PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____

Dental Insurance Company: _____

SECONDARY INSURANCE INFORMATION:

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____

Dental Insurance Company: _____

ASSIGNMENT AND RELEASE

I accept the financial responsibility of all dental services rendered. If I have dental insurance, I authorize that my insurance benefits be paid directly to the dentist. I authorize the dentist to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services.

Signature of Responsible Party: _____

Date: _____

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Medical Doctor Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: (If different from patient) _____

In case of Emergency notify: _____ Phone: _____

Please mark YES or NO to the following medical questions.

Has there been any change in your general health within the past year? ☐ Yes ☐ No

If yes, please explain: _____

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

-Heart condition? ☐ Yes ☐ No
-Heart attack? ☐ Yes ☐ No
-Cardiac pacemaker? ☐ Yes ☐ No
-Damaged or artificial heart valve? ☐ Yes ☐ No
-Mitral valve prolapse? ☐ Yes ☐ No
-Heart murmur? ☐ Yes ☐ No
-Rheumatic fever? ☐ Yes ☐ No
-High blood pressure? ☐ Yes ☐ No
-Low blood pressure? ☐ Yes ☐ No
-Prosthetic joints or limbs? ☐ Yes ☐ No
-Pain in your chest upon exertion? ☐ Yes ☐ No
-Shortness of breath after mild exercise? ☐ Yes ☐ No
-Asthma? ☐ Yes ☐ No
-Swollen ankles? ☐ Yes ☐ No
-Sinus trouble? ☐ Yes ☐ No
-Fainting spells or seizures? ☐ Yes ☐ No
-Diabetes? ☐ Yes ☐ No
-Hepatitis, jaundice, or liver disease? ☐ Yes ☐ No
-Arthritis? ☐ Yes ☐ No
-Stomach ulcers? ☐ Yes ☐ No

(Please complete Page 2 and sign and date)

PATIENT MEDICAL HISTORY (Page 2)

-Tuberculosis? ☐ Yes ☐ No
-Persistent cough or cough up blood? ☐ Yes ☐ No
-Venereal disease? ☐ Yes ☐ No
-Epilepsy? ☐ Yes ☐ No
-Cancer? ☐ Yes ☐ No
-HIV positive? ☐ Yes ☐ No
-AIDS or other immunosuppressive disorder? ☐ Yes ☐ No
-Blood disorder? ☐ Yes ☐ No
-Osteoporosis? ☐ Yes ☐ No
If yes, please list current or past medications (IV or Oral): _____

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No
Are you allergic to any medications or have allergies? ☐ Yes ☐ No
If yes, please list: _____

Are you taking any drugs or medication? ☐ Yes ☐ No
If yes, please list: _____

Have you had any disease, condition, or operation not listed above? ☐ Yes ☐ No
If yes, please list: _____

Have you had any serious trouble associated with any previous dental treatment?
☐ Yes ☐ No
If yes, please explain: _____

WOMEN ONLY:
Are you taking oral contraceptives? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

I certify that I have read and understand the above questions. I acknowledge that my questions have been answered accurately and completely.

_____ Date: _____
Signature of Patient (or Responsible Party)

DENTAL STAFF NOTES:

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ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (mark one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please note: It is your right to refuse to sign this Acknowledgement.

_____
Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt our **Notice of Privacy Practices,** but could not be obtained because:
☐ An emergency prevented us from obtaining acknowledgement.
☐ A communication barrier prevented us from obtaining acknowledgement.
☐ The individual was unwilling to sign.
☐ Other: _____

Staff Signature: _____ Date: _____

Patient Communication Form

By signing below, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders, information about treatment, payment, my account or insurance using voice or telephone equipment by ***calling and texting, or by email and US Mail.***

Patient Signature: _____ Date: _____

OR

Signature of Personal Representative: _____

Updated Phone Number Preference: _____

(Please include Area Code)