PATIENT REGISTRATION FORM

PATIENT PERSONAL INFORMATION:

Patient Name: _____ SSN: _____

Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Sex: M / F Home Phone: _____

Patient Home Address: _____
Street Address

___ Please check if new home address _____
City State Zip

Patient referred by: _____

Responsible party (person responsible for payment/insurance): Self / Spouse / Parent / Other _____

Responsible party information (if different from self):

Name: _____ Home Phone: _____ Work Phone: _____

_____ _____
Street Address City State Zip

PATIENT EMPLOYER INFORMATION: (If retired, please list former employer name.)

Employer Name: _____ Status: Active / Retired
Full-time / Part-time

Employer Address: _____
Street Address

_____
City State Zip

Employer Phone: _____

SPOUSE/RESPONSIBLE PARTY EMPLOYER INFORMATION: (If retired, please list former employer name.)

Employer Name: _____ Status: Active / Retired
Full-time / Part-time

Employer Address: _____
Street Address

_____
City State Zip

Employer Phone: _____

(OVER FOR SIGNATURE)

PATIENT REGISTRATION FORM

PATIENT DENTAL INSURANCE INFORMATION - PRIMARY:

The following information can be found on your Dental Insurance Card or Dental Claim Form. Please check if new insurance coverage. ____

Employer Name (company that provides primary insurance) : _____

Primary Responsible Party: _____

Primary Responsible Party SSN: _____ Birth Date:_____

Primary Insurance Company Name: _____

Primary Insurance Company Address: _____
Street Address

_____
City State Zip

Primary Insurance Phone: _____

Primary Insurance Group/Policy #: _____

PATIENT DENTAL INSURANCE INFORMATION - SECONDARY:

The following information can be found on your Dental Insurance Card or Dental Claim Form. Please check if new insurance coverage. ____

Employer Name (company that provides secondary insurance) : _____

Secondary Responsible Party: _____

Secondary Responsible Party SSN: _____ Birth Date:_____

Secondary Insurance Company Name: _____

Secondary Insurance Company Address: _____
Street Address

_____
City State Zip

Secondary Insurance Phone: _____

Secondary Insurance Group/Policy #: _____

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 Patient (or responsible party) Date

PATIENT MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex: Male / Female

Medical Doctor Name: _____ Medical Doctor Phone: _____

What is your relationship to the patient?

Self / Spouse / Parent / Other: _____

Name: (If different from patient) _____

In case of emergency notify: _____ Phone: _____

Please circle **Yes** or **No** to the following medical questions.

1. Has there been any change in your general health within the past year? Yes / No
   If yes, please explain: _____

2. Do you have or have you had any of the following medical problems?

   - 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

(OVER FOR SIGNATURE)

- 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 disorders? Yes / No
- Blood disorders? Yes / No

3. Do you smoke or use smokeless tobacco? Yes / No

4. Are you allergic to any medications or have allergies? Yes / No
   If yes, please list: _____

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

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

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

WOMEN ONLY

1. Are you taking oral contraceptives? Yes / No

2. 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.

_____ _____

Signature of Patient (or responsible party) Date

Dental Staff Notes:

_____

_____

_____

Theil Theil
D.D.S.

General Dentistry

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 (check 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 of our Notice of Privacy Practices, but it 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 Member Signature Date

5509 Brandt Pike • Huber Heights, Ohio 45424 • 937.233.7121

Theil & Theil
D.D.S.

General Dentistry

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: _____

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