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

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:

____

____

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: ______________

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