

## Patient Registration Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

### Names and ages of family members:

Name	Age	Boy	Girl	Spouse
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Your Employment Information:

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Present Position: \_\_\_\_\_ How long: (years) \_\_\_\_\_ (months) \_\_\_\_\_

Dental Insurance Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Local #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ ☐ Husband ☐ Wife

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Present Position: \_\_\_\_\_ How long: (years) \_\_\_\_\_ (months) \_\_\_\_\_

Dental Insurance Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Local #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Other \_\_\_\_\_

Dental Information

1. How long has it been since your last dental visit?  
☐ Less than 6 months    ☐ 6 months    ☐ 1 year    ☐ 2 years    ☐ Over 2 years
2. Why did you leave your last dentist?  
☐ I moved    ☐ Did not have my interests in mind    ☐ I had financial problems within the office  
☐ The dentist moved    ☐ Did not explain things    ☐ Unresolved problems with office  
☐ I always had to wait    ☐ Was not gentle    ☐ Prefer not to say  
☐ Inconvenient hours    ☐ Office staff was uncaring
3. Why did you choose to come in at this time?  
☐ General Checkup    ☐ I have areas of pain  
☐ I have broken fillings or teeth    ☐ I've put it off too long    ☐ Other \_\_\_\_\_
4. How would you describe the general condition of your teeth?  
☐ Excellent    ☐ Good    ☐ Fair    ☐ Poor
5. If you could change the appearance of your teeth, what would you change?  
☐ Color    ☐ Crowding or crooked teeth    ☐ Black discolored filling    ☐ Other \_\_\_\_\_
6. Do you believe that having your teeth cleaned regularly will help prevent gum disease, and thereby prevent you from losing your teeth?    ☐ Yes    ☐ No
7. Do you smoke a pack or more of cigarettes a day?    ☐ Yes    ☐ No
8. Do you believe dental disease is avoidable?    ☐ Yes    ☐ No
9. Are you apprehensive about your visit here?    ☐ Yes    ☐ No

THIS IS MY AUTHORIZATION TO DR. \_\_\_\_\_ TO PERFORM ALL NECESSARY DIAGNOSTIC, PREVENTIVE, RESTORATIVE, SURGICAL, ORTHODONTIC AND ASSOCIATED DENTAL TREATMENT. I WILL BE ADVISED OF ALL METHODS, MEDICATIONS AND AGENTS AS MAY BE INDICATED AND CONSENT THEREBY, MY CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED IN WRITING.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED, \_\_\_\_\_, FOR DENTAL BENEFITS. OTHERWISE MADE PAYABLE TO ME FOR DENTAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE: \_\_\_\_\_ SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

## Health History

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex ☐ M ☐ F  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_

**For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.**

### Dental Information

Yes No Don't Know				Yes No Don't Know			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic (braces) treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches, earaches or neck pains?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets or pressure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious/difficult problem	associated with any previous dental treatment? If so, explain			

How would you describe your current dental problem? \_\_\_\_\_

Date of your last dental exam \_\_\_\_\_ Date of last dental X-Ray \_\_\_\_\_

What was done at that time? \_\_\_\_\_ Date of last dental X-Ray \_\_\_\_\_

How do you feel about the appearance of your teeth?

### Medical Information

**Yes No Don't Know**

☐ ☐ ☐ Are you in good health?

☐ ☐ ☐ Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems:

☐ ☐ ☐ Active Tuberculosis

☐ ☐ ☐ Persistent cough greater than a 3 week duration

☐ ☐ ☐ Cough that produced blood

☐ ☐ ☐ Are you under the care of a physician? If so, what is /are the condition(s) being treated? \_\_\_\_\_

Physician(s) \_\_\_\_\_

Name	Phone	Address
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?		

☐ ☐ ☐ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? \_\_\_\_\_

Are you taking, or have you taken, any diet drugs such as Pondimin (fenduramine), Reduz (dexphenfluramine) or phen-  
fen(Phentermine)?

☐ ☐ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_ In the past month? \_\_\_\_  
If yes, \_\_\_\_ # of drinks per day for \_\_\_\_ # of years

☐ ☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No

☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list \_\_\_\_\_  
Frequency of use (daily, weekly, etc.) \_\_\_\_\_ Number of years of recreational drug use \_\_\_\_\_

☐ ☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not

**Allergies – Are you allergic to or have you had a reaction to:** (please fill out both columns)

Yes				No				Don't Know			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food (Specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____ (Specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____ (Specify)

To yes responses, specify type of reaction

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing?



- Please (x) if you have or had any of the following diseases or problems.

☐ ☐ ☐ Chest pain upon exertion

**Note:** Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

Signature of Patient/Legal Guardian

Date \_\_\_\_\_

**For completion by dentist**

Comments on patient interview concerning health history

### Significant findings from questionnaire or oral interview

## Dental management considerations

Signature of Dentist

Date \_\_\_\_\_

**Health History Update:** On a regular basis the patient should be questioned about any medical history changes, date and comments noted, along with signatures.

Date \_\_\_\_\_

Comments

Signature of Patient and dentist


# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

twincitydentalcarestx@gmail.com  
(340)778-8155

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

# **CANCELLATION AND NO SHOW** **POLICY**

We understand that situations arise in which you must cancel your appointment. We require that if you must cancel your appointment, you provide minimum 24 hours' notice. It is difficult to schedule same day appointments and often valuable chair space goes unused. Timely notice will enable us to fill that appointment with another patient in need.

Office appointments which are cancelled with less than 24 hours notification may be subject to a \$75 cancellation fee.

We provide a courtesy confirmation call but it is your responsibility to confirm or cancel your appointment with us 1 to 2 days prior to your appointment. It is also your responsibility to update us with any changes to your contact information.

If a patient breaks our cancellation policy three or more times, they will be subject to being dismissed from our practice.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before any future appointments will be scheduled.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these circumstances may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancelation and no-show fees should be directed to our office at 340-778-8155.

**Please sign that you have read, understand and agree to this Cancellation/ No Show Policy**

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date