Twin City Dental Care
twincitydentalcarestx@gmail.com
(340)778-8155

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
_____	_____	□	□	□
_____	_____	□	□	□
_____	_____	□	□	□

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? _____
Name Relationship

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 not 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	
□	□	□	Do your gums bleed when you brush?	□	□	□	Have you ever had orthodontic (braces) treatment?
□	□	□	Have you had any periodontal (gum) treatments?	□	□	□	Do you have headaches, earaches or neck pains?
□	□	□	Do you wear removable dental appliances?	□	□	□	Are your teeth sensitive to cold, hot, sweets or pressure?

□ □ □ 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? _____
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
□ □ □ 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 (fendiuramine), 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
□ □ □ Do you wear contact lenses?

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

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

To yes responses, specify type of reaction _____

Yes	No	Don't Know	
□	□	□	Are you pregnant?
□	□	□	Nursing?

□ □ □ Taking birth control pills?
□ □ □ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
□ □ □ Have you ever had any complications or difficulties with your orthopedic joint?
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose, and what reason? _____
Name of physician or dentist* _____ Phone _____

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

Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know	
□	□	□	Abnormal bleeding	□	□	□	Disease, drug or radiation	□	□	□	Neurological disorders
□	□	□	AIDS or HIV induced immunosuppression				If yes, specify _____				
□	□	□	Anemia	□	□	□	Diabetes, if yes specify type	□	□	□	Osteoporosis
□	□	□	Arthritis	□	□	□	Dry mouth	□	□	□	Persistent swollen glands in neck
□	□	□	Rheumatoid arthritis	□	□	□	Eating disorder	□	□	□	Respiratory problems
□	□	□	Asthma	□	□	□	Epilepsy	□	□	□	Severe headaches
□	□	□	Blood Transfusion	□	□	□	Fainting spells or seizures	□	□	□	Severe or rapid weight loss
			If yes, date _____	□	□	□	G.E. reflux	□	□	□	Sexually transmitted diseases
□	□	□	Cancer/chemotherapy			□	Glaucoma			□	Sinus trouble
			Radiation treatment	□	□	□	Hemophilia	□	□	□	Sleep disorder
□	□	□	Cardiovascular disease	□	□	□	Hepatitis, jaundice or liver disease	□	□	□	Sores or ulcers in the mouth
			If yes, specify	□	□	□	Recurrent infections	□	□	□	Stroke
			O Angina				Indicate type of infection	□	□	□	Systemic lupus erythematosus
			O Arteriosclerosis				_____	□	□	□	Thyroid problems
			O Artificial heart valve	□	□	□	Kidney problems	□	□	□	Tuberculosis
			O Coronary insufficient	□	□	□	Low blood pressure	□	□	□	Ulcers
			O Damages heart valves	□	□	□	Mental health disorders	□	□	□	Excessive urination
			O Heart attack				If yes, specify below:	□	□	□	Do you have any disease,
			O Heart murmur				_____				conditions, or problem not listed
			O High blood pressure				_____				above that you think I should
			O Inborn heart defects	□	□	□	Malnutrition				know about? Please explain:
			O Mitral valve prolapse	□	□	□	Migraines				_____
			O Pacemaker	□	□	□	Night sweats				
			O Rheumatic Heart disease								
□	□	□	Chest pain upon exertion								

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
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 notated, 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 out 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. Out 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.