MOUA
FAMILY DENTISTRY

PATIENT REGISTRATION FORM

FOR OFFICE USE
☐MINOR (under 18)
☐ADULT

PATIENT INFORMATION

Name: _____ **DOB:** _____
Last First Middle Initial

Address: _____
Street/Apt. # City State Zip Code

Telephone: (Home/Cell)_____ (Work)_____ (Email)_____

Preferred method of contact: ☐Home ☐Cell ☐Work ☐Email **Gender:** ☐Male ☐Female ☐Other_____

Please *check* correct option(s) below: (**Insurance Required:** ☐Male ☐Female)

Language	☐English ☐Other (specify):
Race	☐Asian ☐African American ☐Caucasian ☐Native American ☐Hawaiian ☐Pacific Islander ☐Other (specify):
Ethnicity	☐Hispanic ☐Hmong ☐Karen ☐Somali ☐Other (specify):
Status	☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed ☐Minor/child
Referred by	☐Insurance Plan ☐Family/friends ☐Walk-in ☐Dental Office ☐Other (specify):

GUARDIAN INFORMATION (*For Minor (under 18) or patient who cannot consent to their treatment).*

Guardian Name:_____
Date of Birth:_____
Telephone:_____
Address (if different from patient):_____
_____
Relation:_____
(Father/Mother/Legal Guardian)

Guardian Name:_____
Date of Birth:_____
Telephone:_____
Address (if different from patient):_____
_____
Relation:_____
(Father/Mother/Legal Guardian)

EMERGENCY CONTACT: ***In case of a medical emergency, who may we contact?***

Full Name:_____ Tel:_____ Relation:_____

INSURANCE INFORMATION

Primary Insurance Carrier
Policy Holder Information:
Full Name:_____
Date of Birth:_____
Plan Name:_____
ID:_____
Group No.:_____
Service Telephone:_____
Claims Address:_____
_____

Secondary Insurance Carrier
Policy Holder Information:
Full Name:_____
Date of Birth:_____
Plan Name:_____
ID:_____
Group No.:_____
Service Telephone:_____
Claims Address:_____
_____

* * * * * * * *

I authorize the treating dentist to perform diagnostic procedures and treatment as indicated for my (or my child's) proper dental care. I authorize release of any information concerning my (or my child's) heath care, advice, and treatment to another dentist.

I understand that dental treatment recommendations are subject to change as treatment progresses due to unforeseen complexities. I certify that all of the above information is true and correct to the best of my knowledge.

Signature:_____ **Date**:_____
Patient/Parent/Legal Guardian

Interpreter/Witness Name:_____ **Date**:_____

MEDICAL ALERT

Do you have any of the following:

ALLERGY

- ☐ Amoxicillin Allergy
- ☐ Aspirin/Ibuprofen Allergy
- ☐ Augmentin Allergy
- ☐ Epinephrine Sensitivity Allergy
- ☐ Erythromycin Allergy
- ☐ Clindamycin Allergy
- ☐ Codeine/Other Painkillers Allergy
- ☐ Iodine Allergy
- ☐ Latex or Rubber Product Allergy
- ☐ Local Anesthetics Allergy
- ☐ Metal Allergy
- ☐ Penicillin Allergy
- ☐ Sedatives or Barbiturates Allergy
- ☐ Sulfa Drugs Allergy
- ☐ Other Allery (*Please list on Medical Questionnaire form below*)

Are you using the following:

- ☐Antibiotics
- ☐ Anticoagulants/Blood Thinners
- ☐ Aspirin
- ☐ Cortisone/Prednisone
- ☐ High Blood Pressure Medication
- ☐ Insulin
- ☐ Motrin/Aleve/Ibuprofen
- ☐ Oral Anti-Diabetic
- ☐ Nitroglycerin

Currently or ever taken:

- ☐ Actonel
- ☐ Boniva
- ☐ Fosamax
- ☐ Prolia
- ☐ Reclast
- ☐ Zometa
- ☐ Other Bisphosphonates

Check all that applies:

- ☐ Alcohol/Drug Abuse
- ☐ Cancer/Tumor Growth
- ☐ Chemotherapy/Radiation
- ☐ Speech Issues
- ☐ Developmental Delay
- ☐ Learning Disability
- ☐ Organ Transplant
- ☐ Sensory Integration Disorder
- ☐ Wheelchair

IMMUNE SYSTEMS PROBLEMS

- ☐ AIDS/HIV
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Lupus
- ☐ Rheumatoid Arthritis

EYES, EARS, NOSE & THROAT PROBLEMS

- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Ear Aches (Otitis)
- ☐ Dry Mouth (Sjogren)
- ☐ Glaucoma
- ☐ Large Tonsils or Adenoids
- ☐ Hay Fever/Seasonal Allergies
- ☐ Hearing Impaired
- ☐ Sinus Problems
- ☐ Vision Loss

HEART PROBLEMS

- ☐ Mitral Valve Prolapse
- ☐ Angina
- ☐ Chest Pain
- ☐ Congenital Heart Defects
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Damage
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Rheumatic Fever

LUNG PROBLEMS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Reactive Airway Disease
- ☐ Shortness of Breath
- ☐ Sleep Apnea (snoring)

ENDOCRINE PROBLEMS

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Low Blood Sugar
- ☐ Thyroid Problems
- ☐ Hormone Problems

VASCULAR/BLOOD PROBLEMS

- ☐ Anemia
- ☐ Leukemia
- ☐ Excessive, Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Bypass Surgery

GASTROINTESTINAL PROBLEMS

- ☐ Acid Reflux
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Intestinal Bleeding
- ☐ Ulcer

GENITOURINARY PROBLEMS

- ☐ Dialysis
- ☐ Kidney Disease/Failure
- ☐ Urinary Tract Infections

MUSCLE/BONE/SKIN PROBLEMS

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ History of Skin Problems
- ☐ Joint Problems
- ☐ Muscle Problems
- ☐ Neck Problems
- ☐ Osteoporosis

NERVOUS SYSTEM PROBLEMS

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anorexia / Bulimia (eating disorders)
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Traumatic Brain Injury (TBI)
- ☐ Migraines
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Seizures
- ☐ Stroke
- ☐ Other Psychiatric Conditions

OTHER PROBLEMS

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Memory Problems
- ☐ History of Abuse/Trauma
- ☐ Other Medical Condition

MEDICAL HISTORY

Patient Name:_____ DOB:_____

MEDICAL QUESTIONNAIRE

1. Primary Physician Name/Address/Phone:_____
2. Referring Physician Name/Address/Phone (if applicable):_____
3. Are you in good health? ☐ Yes ☐ No
4. When was your last physical exam?_____
5. Are you currently under the care of a physician? ☐ Yes, Explain:_____ ☐ No
6. Have you had any serious illness, operations, accident, or been hospitalized? ☐ Yes, Explain:_____ ☐ No
7. Has there been any changes in your general health in the past year? ☐ Yes, Explain:_____ ☐ No
8. Do you have any of the following? ☐ Yes ☐ No
   ☐ Active tuberculosis ☐ Coughing up blood.
   ☐ Been exposed to anyone with active tuberculosis
   If "YES" to Q8, please notify the receptionist immediately.
9. Have you had any complications with general or local anesthesia? ☐ Yes, Explain:_____ ☐ No
10. Are you currently taking any medication including OTC, vitamins or herbal remedies? ☐ Yes, Explain:_____ ☐ No
11. Do you have any allergies (other than above)? ☐ Yes, Explain:_____ ☐ No

NOTE: **Questions 10 & 11: Please used form below to add all medications and allergies.*

WOMEN ONLY

1. Are you pregnant or is there a chance that you may be pregnant? ☐ Yes, Due Date/explain:_____ ☐ No
2. Are you currently nursing/breast feeding? ☐ Yes ☐ No

FAMILY/PERSONAL/SOCIAL HISTORY

1. Is your mother currently healthy? ☐ Yes ☐ No, Explain:_____
2. Is your father currently healthy? ☐ Yes ☐ No, Explain:_____
3. Do you now or have you ever used:
   a. Tobacco/Chew/E-cigarettes: ☐ Yes; Frequency_____Duration_____Quit Date___ ☐ No
   b. Alcohol: ☐ Yes; Frequency_____Duration_____Quit Date___ ☐ No
   c. Recreational/illicit drugs: ☐ Yes; Frequency_____Duration_____Quit Date___ ☐ No

By signing below, I certify that all of the above information is true to the best of my knowledge.

Signature:_____ **Date:**_____
Patient/Parent/Legal Guardian

Interpreter/Witness Name:_____ **Phone:**_____

PATIENT MEDICATION & ALLERGY FORM

Patient Name:_____ DOB:_____ Gender: ☐ Male ☐ Female

Medication & Dosage	Indication for Use	Start Date

Allergy List	Reaction/Symptoms	Date

DENTAL HISTORY

DENTAL QUESTIONNAIRE

1. What is the reason for your office visit today?_____
2. Name/Address/Phone of previous or referring dentist:_____
3. When did you last visit a dentist?_____
4. What was done at your last visit to the dentist?_____
5. Date of your last cleaning?_____
6. Date of your last exam?_____
7. Date of your last full series of x-rays?_____
8. Date of last cavity detection (Bitwing) x-rays?_____
9. Has any treatment been recommended to you that you have not done?_____
10. Are you aware of any dental problems?_____
11. What do you feel is the current condition of your mouth?_____
12. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
13. Have you ever been treated for gum disease? ☐ Yes;when and what was done:_____ ☐ No
14. Are your teeth sensitive to any of the following? ☐ Yes**:** ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure ☐ No
15. Are you happy with the appearance of your smile? ☐ Yes ☐ No, Explain:_____
16. Do you grind your teeth (bruxism)? ☐ Yes ☐ No
17. Do you have TMD or pain in your jaw joint (TMJ)? ☐ Yes ☐ No
18. Have you had any injury to your teeth, jaw or face? ☐ Yes ☐ No
19. Do you have dental anxiety? ☐ Yes ☐ No
    a. If yes, is there anything that helps alleviate the anxiety?_____

Signature:_____ **Date:**_____
Patient/Parent/Legal Guardian

Interpreter/Witness Name:_____ **Phone:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities 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 other important matters about your protected health information. A copy of our Notice of Privacy Practices 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. These changes may apply to any of your protected health information that we maintain.

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

Clinic Manager
1714 Cope Avenue East
Maplewood, MN 55109
Tel: 651-340-7285

Consent <u>Does Not</u> Expire after One Year. By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for **l)** the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer 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 continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

FOR TELEPHONE, TEXT, EMAIL COMMUNICATIONS

Patient consent to the following: This Dental Practice or its service provider may contact me to provide health care information such as appointment reminders about treatment, payment, my insurance, my account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing.

SIGNATURE

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. 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:**_____
Patient/Parent/Legal Guardian

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

Personal Representative Name:_____ **Relation to Patient:**_____

NOTE: A parent is considered a Personal Representative for a minor under the HIPPA Privacy Regulations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGNED IT