



Registration and Health History form

WE HAVE THE INTEREST AND DESIRE TO LISTEN, REALLY LISTEN, TO WHAT YOU ARE SAYING. PLEASE DON'T HESITATE TO ASK ABOUT ANYTHING YOU DON'T UNDERSTAND. YOU ARE DEALING WITH MEMBERS OF A TEAM WHOSE PRIMARY JOB IS TO SERVE YOU. WE PROMISE THAT YOU WILL NEVER LEAVE FEELING THAT NO ONE CARES.

In order to begin treatment the following information is necessary. Please complete fully and print legibly. All information will be held in strict confidence.

Name _____ Home Ph _____ Cell Ph _____ Spouse's Name _____
Last First Middle

If patient is a minor, please give the name of a parent or legal guardian _____
Last First Middle

Residence Address _____ City _____ State _____ Zip Code _____
Street

Mailing Address (if different than residence) _____ City _____ State _____ Zip Code _____
Street

Date of Birth _____ SS# _____ Sex M F Email _____

Driver's License _____ Occupation _____ Employer _____

Employer Address _____ City _____ State _____ Zip Code _____

Emergency Contact _____ Relationship _____ Phone _____
Name Relationship

If you are completing this form for another person, what is your relationship to that person? _____

How may we contact you? Phone _____ Mail _____ Email _____ Text Message _____ All _____

INSURANCE

Policy Holder _____ Relationship to Patient _____ Insured DOB _____

SS# of Insured _____ Insured Employer _____ Insurance Company _____

Secondary Insurance Yes No - If Yes, Policy Holder _____ Relationship to Patient _____

Insured DOB _____ SS# of Insured _____ Insured Employer _____

DENTAL INFORMATION

For the following questions, please (X) whichever applies. This information is vital to allow us to provide appropriate care for you.

- | | |
|--|---|
| Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Do your gums occasionally bleed when you brush? | <input type="checkbox"/> <input type="checkbox"/> Have you ever had orthodontic (braces) treatment? |
| <input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets or pressure? | <input type="checkbox"/> <input type="checkbox"/> Do you have headaches, earaches or neck pain? |
| <input type="checkbox"/> <input type="checkbox"/> Have you had any periodontal (gum) treatments? | <input type="checkbox"/> <input type="checkbox"/> Do you wear removable dental appliances? |
| <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? _____

Former Dentist _____ Reason for leaving _____

Date of your last dental exam _____ Date of last dental x-ray _____ What was done at that time? _____

Are you nervous about receiving dental care? Yes No Would you like to be sedated for treatment? Yes No

Are you participating in any sport? Yes No Do you wear a mouth guard? Yes No

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

These questions are for your benefit and assure that the treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral care.

- Yes No
- Are you in good health?
 - Have there been any changes in your general health within the past year?
 - Are you under the care of a physician? If so, what is/are the condition(s) being treated? _____
Date of last physical examination _____ Physician _____
 - Have you had any serious illness, operation, hospitalized in the past 5 years? If so, what was the illness or problem? _____

Yes No
 Are you taking or have you recently taken any medicine(s) including no-prescription medicine? If so, what are you taking and what is the dosage?
 Prescribed _____
 Over the counter _____
 Natural or herbal preparations _____

Have you taken any of the following prescription medications? Circle one ZOMETA AREDIA ACTONEL BONIVA FOSAMAX

Do you drink alcoholic beverages? If Yes, how much alcohol did you drink in the last 24 hours? _____

Are you alcohol and/or drug dependent? If so, have you received treatment? 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 Yes, how much? _____

Do you wear contact lenses? _____

ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT EACH COLUMN)

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Local anesthetics	<input type="checkbox"/> <input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> <input type="checkbox"/> Hay fever/seasonal
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics	<input type="checkbox"/> <input type="checkbox"/> Animals
<input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Food (specify) _____
<input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/> <input type="checkbox"/> Iodine	<input type="checkbox"/> <input type="checkbox"/> Other (specify) _____

To Yes responses, please type of reaction _____

Yes No
 Nursing?
 Are you pregnant? If Yes, how many months? _____
 Taking birth control pills?

Do you now or have you ever had any of the following? Please check YES or NO to ALL

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> <input type="checkbox"/> Disease, drug or radiation induced immunosuppression	<input type="checkbox"/> <input type="checkbox"/> Nights sweats
<input type="checkbox"/> <input type="checkbox"/> AIDS or HIV infections	<input type="checkbox"/> <input type="checkbox"/> Dry mouth	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Angina. If YES date: _____	<input type="checkbox"/> <input type="checkbox"/> Eating disorder. If YES, specify: _____	<input type="checkbox"/> <input type="checkbox"/> Persistent swollen glands/neck
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Recurrent infections
<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Excessive urination	<input type="checkbox"/> <input type="checkbox"/> Respiratory problems
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Fainting spells or seizures	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> G.I. reflux	<input type="checkbox"/> <input type="checkbox"/> Severe headaches / migraines
<input type="checkbox"/> <input type="checkbox"/> Blood transfusion If YES, date: _____	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Severe or rapid weight loss
<input type="checkbox"/> <input type="checkbox"/> Cancer/chemotherapy/radiation treatment If YES, date: _____	<input type="checkbox"/> <input type="checkbox"/> Heart attack. If YES, date: _____	<input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> <input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Sinus trouble
<input type="checkbox"/> <input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice or liver disease	<input type="checkbox"/> <input type="checkbox"/> Sores or ulcers in the mouth
<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Stroke. If YES, date: _____
<input type="checkbox"/> <input type="checkbox"/> Damaged heart valves	<input type="checkbox"/> <input type="checkbox"/> Implants	<input type="checkbox"/> <input type="checkbox"/> Systemic lupus erythematosus
<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Joint replacement, If YES, date: _____ Where: _____	<input type="checkbox"/> <input type="checkbox"/> Thyroid problems
<input type="checkbox"/> <input type="checkbox"/> Inborn heart defects	<input type="checkbox"/> <input type="checkbox"/> Kidney problems	<input type="checkbox"/> <input type="checkbox"/> TMJ
<input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Rheumatic heart disease	<input type="checkbox"/> <input type="checkbox"/> Mental health disorders. If YES, specify: _____	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Chronic pain	<input type="checkbox"/> <input type="checkbox"/> Neurological disorders. If YES, specify: _____	<input type="checkbox"/> <input type="checkbox"/> Do you have any disease, condition or problem not listed above that you think I should know about? Please explain: _____
<input type="checkbox"/> <input type="checkbox"/> Chest pain upon exertion		
<input type="checkbox"/> <input type="checkbox"/> Diabetes, If YES specify below: _____		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose? _____

Who may we thank for referring you to our office? _____

I certify that I have read and understand the above. To the best of my knowledge, all of the preceding answers are true and correct I understand that it is my responsibility to advise this office of any changes in the information contained on this form. I acknowledge that my questions if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsibility for any action they take to do not take because of errors or omissions that I may have made in the completion of this form. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable before or at the time of service unless other arrangements have been made. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to the use the appropriate medication and therapy indicate for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnoses of any dental needs I hereby authorize my dentist to release any and all medical or dental information to my insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

_____ Signature of Patient / Legal Guardian	_____ Date	_____ Date	_____ Date
_____ Assistant Signature	_____ Date	_____ Dentist Signature	_____ Date

Woodside Dental Care Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize Woodside Dental Care to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice;
- And to anyone I have elected below

Print Name _____ Relationship _____

Print Name _____ Relationship _____

I have also been informed of and given the right to review and secure a copy of Woodside Dental Care's Notice of Privacy Practices, which contains a more completed description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that Woodside Dental Care reserves the right to change the terms of this notice from time to time and that I may contact Woodside Dental Care at any time to obtain the most current copy this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Woodside Dental Care is not required to agree to these requested restrictions. However, if Woodside Dental Care agrees, Woodside Dental Care is bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed _____ day of _____, 20 _____

Print Patient Name _____

Relationship to Patient _____

Signature of Patient _____