Woodside Dental Care — 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 UNDERTSTAND. YOU ARE DEALING WITH MEMEBERS 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 _____ (Last / First / Middle) Home Ph _____ Cell Ph _____ Spouse's Name _____

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

Residence Address _____ (Street) City _____ State _____ Zip Code _____

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

Date of Birth _____ SSN _____ Sex M F Email _____

Drivers License _____ Occupation _____ Employer _____

Employer Address _____ (Street) City _____ State _____ Zip Code _____

Emergency Contact _____ Relationship _____ Phone _____

If you are completing this form for another person, what is your relationship to that person? _____ (Name / Relationship)

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

INSURANCE

Policy Holder _____ Policy to Patient _____ Insured DOB _____

SSN of Insured Insured Employer _____ Insurance Company _____

Second Insurance ☐ Yes ☐ No If Yes, Policy Holder _____ Relationship to Patient _____

Insured's DOB _____ SSN of Insured _____ Insured Employer _____

DENTAL INFORMATION

For the following questions, please check whatever applies. This information is vital to allow us to provide appropriate care for you.

Yes	No		Yes	No	
☐	☐	Do your gums occasionally bleed when you brush?	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	Have you had any periodontal (gum) treatment?	☐	☐	Do you wear removable dental appliances?
☐	☐	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? _____

Yes	No		Yes	No	
☐	☐	Are you nervous about receiving dental care?	☐	☐	Would you like to be sedated for treatments?
☐	☐	Are you a participant in any sport?	☐	☐	Do you wear a mouth guard?

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

MEDICAL INFORMATION

These questions are for your benefit and assure that 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?
☐	☐	Has there been any change in your general health within the past year?
☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s)being treated? _____
		Date of the last physical examination _____ Physician _____
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so what was the illnesss or problem? _____

Yes	No	
☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking and what is the dosage?

Prescribed _____

Over the counter _____

Natural or herbal preparation _____

☐ ☐ 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? _____ Past month? _____

☐ ☐ 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 lens?

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

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Sulfa drugs	☐	☐	Hay fever/seasonal
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Animals
☐	☐	Penicillin or other antibiotics	☐	☐	Latex	☐	☐	Food (specify) _____
☐	☐	Barbiturates, sedatives or sleeping pills	☐	☐	Iodine	☐	☐	Other (specify) _____

To "yes" responses, specify type of reaction _____

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

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

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Disease, drug, or radiation induced immunosurpression	☐	☐	Night sweats
☐	☐	Angina. If yes, date: _____	☐	☐	Dry mouth	☐	☐	Persistent swollen glands/neck
☐	☐	Anemia	☐	☐	Eating disorder. If yes, specify	☐	☐	Recurrent infections
☐	☐	Arteriosclerosis			_____	☐	☐	Respiratory problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Neurological disorders. If yes, specify
☐	☐	Asthma	☐	☐	Excessive urination			_____
☐	☐	Blood transfusion. If yes, date	☐	☐	Fainting spells or seizures			_____
		_____	☐	☐	G.I. reflux	☐	☐	Seizures
☐	☐	Cancer/chemotherapy/radiation treatment. If yes, date	☐	☐	Glaucoma	☐	☐	Severe headache/migraines
☐	☐		☐	☐	Heart attack. If yes, date	☐	☐	Severe or rapid weight loss
☐	☐	Cardiovascular disease	☐	☐	Hemophilia	☐		Sexually transmitted disease
☐	☐	Artificial heart valves	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Sinus trouble
☐	☐	Pacemaker				☐	☐	Sleep disorder
☐	☐	Damaged heart valves	☐	☐	High blood pressure	☐	☐	Sores or ulcers in the mouth
☐	☐	Heart murmur	☐	☐	Implants	☐	☐	Stroke. If yes date _____
☐	☐	Inborn heart defects	☐	☐	Joint replacement. If yes, date	☐	☐	Systemic lupus emphysematous
☐	☐	Mitral valve prolapse			_____	☐	☐	Thyroid problems
☐	☐	Rheumatic heart disease			Where _____	☐	☐	TMJ
☐	☐	Chronic pain	☐	☐	Kidney problems	☐	☐	Tuberculosis
☐	☐	Chest pain upon exertion	☐	☐	Low blood pressure	☐	☐	Ulcers

continued on next page...

☐ ☐ Diabetes. If yes, specify _____

☐ ☐ Mental health problems If yes, specify _____

☐ ☐ Do you have any disease, condition or problem not listed above that you think I should know about? Please explain _____

☐ ☐ 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, 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. 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 use the appropriate medication and therapy indicated 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

_____ _____ _____ _____

Assitant Signature Date Dentist Signature Date

Woodside Dental Care
Patient Consent Form

I understant 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 _____

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