## PATIENT REGISTRATION

Patient Name: ____________________________ Preferred Name: ______________ Date of Birth: ____/____/____

Address: _________________________________ City: ______________________ State/Zip: ____________________

Phone Number: (H/W/C): ______________________________ (H/W/C): ___________________________________

Social Security #: _____-_____-_____ Gender(M/F/Other):___________ Marital Status (S/M/D/W): _____________

E-mail: ____________________________________________________

Responsible for account: Self _______ Other _______ (If other, please fill out the section below.)

Name: ______________________________ Phone Number: ___________________________

Address: ________________________________________ Social Security #: _____-_____-_____

Relationship to Patient: ___________________ Current Employer: _______________________

How did you hear about our office? ________________________________________

## INSURANCE

Please provide a copy of your insurance card

Do you have dental insurance? Yes _____ No_____

If you have our Dental Savings Plan (DSP), please mark here: ______

Primary Insurance:

Insurance Provider: __________________ ID/Member #: _________________________ Group #: _______________

Name of Insured:___________________ Insured Date of Birth: ____/____/____ Insured SSN#: _____-_____-_____

Insured Employer: _______________________ Relationship to Patient: _______________________

Secondary Insurance: (If none, please skip this section)

Insurance Provider: __________________ ID/Member #: _________________________ Group #: _______________

Name of Insured:___________________ Insured Date of Birth: ____/____/____ Insured SSN#: _____-_____-_____

Insured Employer: _______________________ Relationship to Patient: _______________________

## DENTAL HISTORY

Is the patient a minor? Yes______ No______ If yes, is this their first visit to a dentist? Yes______ No______

Previous Provider: ________________________ Previous Provider's Phone #: ______________________

Date of last dental visit (please circle one): 0-6 Months 6 Months - 1 Year 1-2 Years More than 2 years ago

Date of last dental x-rays (if applicable): _____________________

How often do you floss? (please circle one): Daily 2-3 times a week Weekly Never

How often do you brush your teeth? (please circle one): 2-3 times a day Daily 2-3 times a week Never

Circle any that apply: Bleeding, Red/Swollen Gums, Broken/Loose teeth, Clicking jaw, Grinding teeth, Sores/Blisters

Please list any other dental concerns/pain: ____________________________________________________________

Are you interested in whitening your smile? Yes_____ No_____

## MEDICAL HISTORY

Are you currently under the care of a physician? Yes_____ No_____

If yes, Physician Name: ______________________ Physician Phone #: ______________________

Is the patient physically or mentally impaired? Yes_____ No_____ If yes: ____________________________________

Describe the patient's current physical health: Good_____ Fair_____ Poor_____

Emergency Contact Name: __________________ Number: ___________________ Relationship: ________________

**Circle/Mark all that apply:**

High/Low Blood Pressure _____

Diabetes _____

Fainting/Dizziness _____

Breathing Problems/Asthma _____

Heartburn/GERD _____

Bleeding Problems _____

Sinus Trouble _____

Heart Problems _____

Kidney Disease _____

Liver Disease _____

Thyroid Problems _____

Artificial Joints _____

Artificial/Damaged Heart Valves _____

Cancer Type; ____________ _____

Chemotherapy/Radiation _____

AIDS/HIV _____

Frequent Headaches/Migraines _____

Psychiatric Care _____

Do you smoke/vape? _____

Do you drink alcohol? _____

Use controlled substances? _____

High sugar intake? _____

-WOMEN ONLY-

Are you pregnant? _____

Are you nursing? _____

**List any prescription or over the counter medications:**

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

**List any other serious illnesses or hospitalizations:**

______________________________

______________________________

______________________________

______________________________

**List any allergies:**

______________________________

______________________________

______________________________

______________________________

***By signing the line below, I confirm that this form is filled out to the best of my abilities.***

Signature:_______________________________________________ Date:____________________

## HIPAA Acknowledgement

The federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## Patient Acknowledgement

Please sign the section below to acknowledge that you have today been offered a copy of our Notice of Privacy Practices.

______________________________ ______________________________

**Patient/Guardian Signature** **Patient/Guardian Name (Printed)**

_______/_______/_________

**Date**

## Patient Consent

I hereby authorize the office of Ideus Family Dental Care to release or share information of my dental records to the following:

______________________________ ______________________________

**Name** **Relationship**

______________________________

**Patient/Guardian Signature**

## Office Appointment Policies

Please be considerate and confirm your appointment by either phone, text, or email. If the appointment is not confirmed, your appointment will be assigned to someone else who is needing that time. Appointments WILL NOT be held without confirmation.

If an emergency should arise, you may cancel your appointment, if possible with a 24 hour notice, and still be able to reschedule. However, any cancellation is evaluated.

If an appointment is canceled on short notice, I.E. less than 24 hours, there will be a $25 charge per half-hour of appointment time.

**Once two appointments have been missed, we will no longer reappoint.**

______________________________________ ______/______/________

**Patient / Guardian Signature** **Date**