

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

emergency contact: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Dr. Kent S. Lamoreux Notice of Privacy Practices for protected health information.

Date: _____

Name of Patient: _____
Print Name

Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- 1 Showing the patient the Notice of Privacy Practices posted in our office.
- 2 Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- 3 Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- 4 Asking the patient to sign this Acknowledgement form.
- 5 Other (explain in detail) _____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- 1 The patient refused to sign this form.
- 2 The patient would not sign the form because the patient said he/she did not understand the Notice.
- 6 Other (explain in detail) _____

Date: _____

Name: _____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatment are provided to the patient after April 14, 2003. This Acknowledgement must be retained in the patient's permanent records.