

PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: Policy Holder
 Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

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

Address: _____

City, State, Zipcode: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Social Security: _____ Driver's License: _____

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

Patient Information

Address: _____

City, State, Zipcode: _____ Date of Birth: _____ Age: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Social Security: _____ Driver's License: _____

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

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hygenist: _____

Referral Source:

Encore Launch Loyalty Discount Plan

Word of Mouth Online

Walk-In Drive-By

PPO Insurance Medicaid

Primary Insurance Information

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

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zipcode: _____ City, State, Zipcode: _____

Remaining Benefits: _____ Remaining Deductible: _____

Secondary Insurance Information

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

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zipcode: _____ City, State, Zipcode: _____

Remaining Benefits: _____ Remaining Deductible: _____

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.

- Has anyone ever said you snore? Yes No If yes, please explain: _____
- Do your tissues ever bleed upon brushing or flossing? Yes No If yes, please explain: _____
- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

What can we do to make you a patient for life? _____

If you had a magic wand and could change anything about your smile what would it be? _____

How long has it been since your last dental visit? _____

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 _____

HISTORIA MEDICA

Nombre del paciente: _ _ _ _ _ Fecha de nacimiento: _ _ _ _ _

Aunque el personal dental principalmente tratan el area y alrededor de su boca, su boca es una parte de su cuerpo. Los problemas de salud que pueda tener, o medicamentos que este tomando, podrian tener una importante relación con la odontologia que usted recibira. Gracias por contestar las siguientes preguntas.

- Si No ¿Alguna vez alguien te ha dicho que roncas?
- Si No ¿Sus tejidos sangran alguna vez al cepillarse o usar hilo dental?
- Si No ¿Esta usted bajo el cuidado de un medico ahora?
- Si No ¿Alguna vez ha sido hospitalizado o tenido una operaci6n mayor? ¿Ha tenido alguna vez una lesion grave en la cabeza o en el cuello? ¿Esta usted tomando algun medicamento, pastillas, o drogas?
- Si No ¿Toma o ha tomado, Phen-Fen o Redux?
- Si No ¿Alguna vez a tomado Fosamax, Boniva, Actonel, o cualquier otro medicamento que contenga bifosfonatos?
- Si No ¿Esta usted en una dieta especial?
- Si No ¿Usa tabaco?
- Si No ¿Listed usa sustancias controladas?

En caso afirmativo, sirvase explicar: _____

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En caso afirmativo, sirvase explicar: _____

Mujeres: ¿Esta usted Embarazada o tratando de quedar embarazada? Si No Toma anticonceptivos orales? Si No Esta amamantando? Si No

Es usted alergico a cualquiera de los siguiente?
 Aspirina Penicilina Codeina Acrilico Metalico Latex Anestésicos locales Sulfamida
 Otros En caso afirmativo, sirvase explicar: _____

¿Tiene, o ha tenido, cualquiera de los siguientes?

- | | | | | | | | |
|--------------------------------|---|----------------------------------|---|--|---|-----------------------------------|---|
| SIDA/ HIV Positive | <input type="checkbox"/> Si <input type="checkbox"/> No | Cortisona | <input type="checkbox"/> Si <input type="checkbox"/> No | Hemofilia | <input type="checkbox"/> Si <input type="checkbox"/> No | Tratamiento con radiacion | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Enfermedad de Alzheimer's | <input type="checkbox"/> Si <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Si <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Si <input type="checkbox"/> No | Perdida de peso reciente | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Anafilaxia | <input type="checkbox"/> Si <input type="checkbox"/> No | Drogadiccion | <input type="checkbox"/> Si <input type="checkbox"/> No | Hepatitis B o C | <input type="checkbox"/> Si <input type="checkbox"/> No | Dialisis renal | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Si <input type="checkbox"/> No | Facilmente pierde el aliento | <input type="checkbox"/> Si <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Si <input type="checkbox"/> No | Fiebre reumatica | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfisema | <input type="checkbox"/> Si <input type="checkbox"/> No | Presion arterial alta | <input type="checkbox"/> Si <input type="checkbox"/> No | Reumatismo | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Artritis/Gota | <input type="checkbox"/> Si <input type="checkbox"/> No | Epilepsia o convulsiones | <input type="checkbox"/> Si <input type="checkbox"/> No | Colesterol Alto | <input type="checkbox"/> Si <input type="checkbox"/> No | Escarlatina | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Valvula del corazon artificial | <input type="checkbox"/> Si <input type="checkbox"/> No | Sangrado excesivo | <input type="checkbox"/> Si <input type="checkbox"/> No | Ronchas o erupcion cutanea | <input type="checkbox"/> Si <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Articulacion artificial | <input type="checkbox"/> Si <input type="checkbox"/> No | Sed excesiva | <input type="checkbox"/> Si <input type="checkbox"/> No | Hipoglucemia | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad de celulas falciformes | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Asma | <input type="checkbox"/> Si <input type="checkbox"/> No | Desmayos l vertigo | <input type="checkbox"/> Si <input type="checkbox"/> No | Latido irregular del corazon | <input type="checkbox"/> Si <input type="checkbox"/> No | Problemas del seno nasal | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Enfermedad arterial | <input type="checkbox"/> Si <input type="checkbox"/> No | Tos frecuente | <input type="checkbox"/> Si <input type="checkbox"/> No | Problemas de los rinones | <input type="checkbox"/> Si <input type="checkbox"/> No | Espina Bifida | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Transfusi6n de sangre | <input type="checkbox"/> Si <input type="checkbox"/> No | Diarrea frecuente | <input type="checkbox"/> Si <input type="checkbox"/> No | Leucemia | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad estomacal/intestinal | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Problemas respiratorio | <input type="checkbox"/> Si <input type="checkbox"/> No | Dolores de cabeza frecuente | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedades del Higado | <input type="checkbox"/> Si <input type="checkbox"/> No | Ataque fulminante | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Si <input type="checkbox"/> No | Glaucomas | <input type="checkbox"/> Si <input type="checkbox"/> No | Presion arterial baja | <input type="checkbox"/> Si <input type="checkbox"/> No | Hinchazi6n de las extremidades | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Moretonescon facilidad | <input type="checkbox"/> Si <input type="checkbox"/> No | Herpes Genital | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad pulmonar | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad de la Tiroides | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Quimioterapia | <input type="checkbox"/> Si <input type="checkbox"/> No | Fiebre del heno | <input type="checkbox"/> Si <input type="checkbox"/> No | Prolapse de la valvula mitral | <input type="checkbox"/> Si <input type="checkbox"/> No | Amigdalitis | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Dolores en el pecho | <input type="checkbox"/> Si <input type="checkbox"/> No | Ataque/Falla del corazon | <input type="checkbox"/> Si <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Si <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Herpes labial/Fiebre Ampollas | <input type="checkbox"/> Si <input type="checkbox"/> No | Soplo cardiaco | <input type="checkbox"/> Si <input type="checkbox"/> No | Dolor en la articulacion de la quijada | <input type="checkbox"/> Si <input type="checkbox"/> No | Tumores o crecimientos | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Cardiopatía congenita | <input type="checkbox"/> Si <input type="checkbox"/> No | Marcapasos en el Corazon | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad paratiroides | <input type="checkbox"/> Si <input type="checkbox"/> No | Ulceras | <input type="checkbox"/> Si <input type="checkbox"/> No |
| Convulsiones | <input type="checkbox"/> Si <input type="checkbox"/> No | Problemas/Enfermedad del coraz6n | <input type="checkbox"/> Si <input type="checkbox"/> No | Atencion Psiquiatrica | <input type="checkbox"/> Si <input type="checkbox"/> No | Enfermedad venerea | <input type="checkbox"/> Si <input type="checkbox"/> No |
| | | | | | | La ictericia amarilla | <input type="checkbox"/> Si <input type="checkbox"/> No |

¿Ha tenido alguna enfermedad grave que no figura en la lista de arriba? Si No En caso afirmativo, sirvase explicar: _____

¿Qué podemos hacer para que seas un paciente de por vida? _____

Si tuvieras una varita mágica y pudieras cambiar algo de tu sonrisa, ¿cuál sería? _____

¿Cuánto tiempo ha pasado desde su última visita al dentista? _____

Comentarios: _____

Que yo sepa, las preguntas en este formulario han sido respondidas con precisión. Entiendo que proporcionar información incorrecta puede ser peligroso para mi salud (o la del paciente). Es mi responsabilidad informar al consultorio dental de cualquier cambio en el estado médico.

Firma del paciente, padre o tutor _____ Fecha. _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NAME: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY# : _____

SECTION B: 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 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 of other important matters about your protected health information. A copy of your Notice 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. Those changes may apply to any of your protected health information that we maintain.

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

CONTACT PERSON: _____

Telephone: _____

E-MAIL _____

ADDRESS _____

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person 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 to continue treating you if you revoke this Consent.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

PLEASE PRINT NAME_____
SIGNATURE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)