PATIENT REGISTRATION

Patient's Name _____ M ____ F ____ Age _____ Date _____

Marital Status S M W D Date of Birth _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Phone # (home) _____(cell) _____ (work) _____

Pharmacy _____ Pharmacy Phone _____

Spouse's Name _____ Parent's Names (if Minor)_____

Person Responsible for Account _____ Relationship _____

Their Address _____ SS#_____ Date of Birth _____

Their Employer _____ Occupation _____

Work Address _____ Work Phone_____

Dental Insurance _____ Policy # _____

Major Medical Insurance _____ Policy # _____

Referred by _____ Patients Dentist_____ Dentists Phone#_____

Physician _____Phone#_____ Specialist _____ Phone#_____

Did you bring referral slip? Yes ____No ___ X –Rays? Yes _____No ___ Height_____ Weight_____

* *

PATIENT MEDICAL HISTORY

If you answer YES to any of the following questions, please explain in the spaces provided or write on the back if additional space is needed.

Yes____ No____ 1. Are you now under a physician's care, or have you been in the last 15 years? _____

Yes____ No____ 2. Are you now taking any kind of medication? Include Aspirin, Motrin products, birth control, or herbal medicines. _____

Yes____ No____ 3. Are you allergic to any medications? List your symptoms for each. _____

Yes____ No____ 4. Have you ever been hospitalized? If so give dates and reasons for each. _____

Have you had any type of surgery? Please list surgeries and dates. _____

Yes____ No____ 5. Have you ever had prolonged bleeding after surgery, extractions, or a cut? _____

Yes____ No____ 6. Have you ever had a difficult extraction? _____

Yes____ No____ 7. Do you or did you ever use any form of tobacco? What kind _____ How much ___ How long _____ Date you quit_____

Yes____ No____ 8. Do you wear contact lenses? _____ Hearing Aids _____ Tongue studs _____ Facial jewelry _____

Yes____ No____ 9. Are you pregnant? _____ Due Date _____ Are you nursing? _____

Yes____ No____ 10. Do you have any health problems we should know about? _____

Yes____ No____ 11. Do you have a family history of any of the following? Please check.

_____ problems with anesthesia, anesthetic drugs, or malignant hyperthermia
_____ heart attacks, heart murmurs, heart problems stokes or vascular disease
_____ lung problems, i.e. asthma
_____ kidney disease, kidney transplants (renal)
_____ cancer
_____ bleeding disorders
_____ birth defects
_____ liver disease, liver transplants

12. Do you now have or have had any of the following, please check and circle:.

_____ heart attack, heart trouble, chest pain, rapid, slow or irregular heart rhythm
_____ shortness of breath, swollen ankles
_____ heart murmur
_____ heart surgery, bypass surgery, angioplasty, stent, valve replacement, etc.
_____ implanted cardiac pacemaker or defibrillator
_____ rheumatic fever, scarlet fever
_____ high blood pressure, elevated triglycerides or cholesterol
_____ stroke
_____ asthma, TB, bronchitis, pneumonia, emphysema
_____ sleep apnea, daytime drowsiness
_____ recent cold or cough
_____ cirrhosis, liver desease, yellow jaundice
_____ hepatitis A B C
_____ alcohol abuse or dependency_____year diagnosed ____ how many drinks per day _____ per week _____
_____ drug or chemical abuse type of drug _____ for how long _____
_____ use of anabolic steroids, HGH, marijuana, or recreational drugs
_____ kidney disease, kidney stones, urinary tract infection, urinary tract disorder
_____ intestinal disease, ulcers, colitis, acid reflux, Crohns disease, diverticulitus
_____ eating disorders, anorexia, bulimia, obesity, weight gain or loss of > 20lbs. in the last year
_____ venereal disease, gonorrhea, syphilis, genital herpes
_____ AIDS (HIV+)
_____ Blood disease, anemia, sickle cell disease
_____ hemophilia, bleeding disorders
_____ porphyria
_____ hypoglycemia
_____ endocrine (gland) disorders, i. e. pituitary
_____ autoimmune disorders, sjogrens, lupus,etc.
_____ skin disease, allergy to tape or latex
_____ skeletal disorders, deformity or bone disease, osteoporosis or medication for this
_____ arthritis, rheumatoid arthritis
_____ glaucoma
_____ thyroid disease
_____ diabetes
_____ menstrual problems, child birth, D&C, hysterectomy
_____ radiation therapy
_____ chemotherapy
_____ cortisone therapy
_____ blood thinners, coumadin, aspirin, etc.
_____ nervous system disorders, seizure, epilepsy
_____ pain disorders
_____ paralysis
_____ dizziness
_____ brain tumor
_____ multiple sclerosis
_____ parkinson's disease
_____ alzheimer's disease (dementia)
_____ mental retardation
_____ psychiatric treatment, depression, anxiety disorder
_____ cancer
_____ artificial heart valve
_____ artificial joint replacement ___right ___left ___knee ___ hip ___other

13. Do you have good exercise tolerance? _____
14. Why are you here? _____
15. What is your chief complaint? _____
16. If you are being sedated: When did you last eat or drink? _____ Who is driving you home? _____

I hereby certify that the above information is correct. I authorize release of any information relating to my treatment and assign insurance benefits to Dr. Perry.

X _____ _____

Signature of patient or guardian Date

R. Thomas Perry, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ e-mail _____

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.

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.

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 office. 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

I, _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____

Signature of patient or authorized representative date

_____

Relationship to patient

INSURANCE INFORMATION

Patient Name _____

Address _____

PRIMARY INSURANCE

Policy Holder _____

Address _____

Date of Birth _____

Insurance ID # (may be social security number) _____

Insurance Company _____

Insurance Address _____

Insurance Phone # _____

Employer _____

SECONDARY INSURANCE

Policy Holder _____

Address _____

Date of Birth _____

Insurance ID # (may be social security number) _____

Insurance Company _____

Insurance Address _____

Insurance Phone # _____

Employer _____