PATIENT REGISTRATION FORM

Today's Date _____

PATIENT REGISTRATION

Patient Name	Nick Name	Birthdate	Sex M F
Address	Zip Code	Phone	
Employer	Business Address		Phone
Yrs. Employed	SSN	Marital Status: S M D W	
Spouse Name	No. of Dependents	Spouse's SSN	
Spouse's Employer		Referred by	
Emergency Contact Name		Phone	

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name		Relationship to Patient	
Street Address		Phone	
Employer	Years Employed	SSN:	
Business Address		Phone	

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name	Employee I.D#	Birthdate	SSN
Employer	Business Address	Insurance Co.	
Group No.	Deductible Met? Yes No	Max Benefit $	Benefit Year
Patient's Relation to Subscriber: Self Spouse Dependent	Have you used your dental insurance this benefit year? Yes No		

SECONDARY INSURANCE

Subscriber's Name	Employee I.D.#	Birthdate	SSN
Employer	Group No.	Insurance Co.	Relationship to Patient

FOR OFFICE USE ONLY

Primary Subscriber's Name		Family Member No.		Emp. No
Secondary Subscriber's Name		Family Member No.		Emp. No
Doctor				
Medical Message				
1. No Message	2. See medical	3. Pre-medicate	4. See Medical and Pre-medicate	5. Allergies

The above information is accurate and complete and to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party _____ Date _____

HEALTH HISTORY

Patient Name: _____ Date: _____

Have you been or are you now under a physician's care? Yes No

If yes, why? _____

Have you ever been hospitalized? Yes No

Reason: _____

Physician's Name: _____

When was your last complete physical? _____

Are you currently taking any medications? Yes No

List: _____

Have you taken any cortisone/had steroid therapy during the past two years? Yes No

Are you allergic to or have any adverse reaction to any of the following medications?

Aspirin	Codeine	Penicillin
Erythromycin	Local Anesthetic	Nitrous Oxide

Are you aware of being allergic to any mediations? Yes No

If yes, please list: _____

Do you have or have you had any of the following:

Artificial Joint	Yes	No	Anemia	Yes	No
Heart Valve Implant	Yes	No	Blood Transfusion	Yes	No
Heart Disease/Attack	Yes	No	Hepatitis/Jaundice/Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	AIDS/HIV Exposure	Yes	No
High/Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Pacemaker	Yes	No	Alcoholism/Drug Abuse	Yes	No
Allergies/Asthma	Yes	No	Radiation Treatment	Yes	No
Sinus Problems	Yes	No	Cancer/Tumor	Yes	No
Epilepsy/seizures	Yes	No	Chemotherapy	Yes	No
Fainting/Dizzy Spells	Yes	No	Malignant Hyperthermia/Family History	Yes	No
Psychiatric Treatment	Yes	No	Ulcers	Yes	No
Glaucoma	Yes	No	Nervous Problems	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No
Eating Disorder	Yes	No	Blood Diseases	Yes	No
Circulatory Problems	Yes	No	Arthritis	Yes	No
Excessive Bleeding from Cut/Injury	Yes	No	Stroke	Yes	No

Do you smoke or chew tobacco? Yes No

How much? _____

Do you consume alcoholic beverages? Yes No

How often? _____

Are you pregnant or suspect you may be? Yes No

Are you nursing Yes No

Are you taking oral contraceptives? Yes No

Do you wear contact lenses? Yes No

Do you have any disease, condition or problem not listed? Yes No

To the very best of my knowledge, the above information is true Yes No

Patient Signature _____ Date _____

Staff Signature _____ Dr. Initial _____

W. Michael Copeland DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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)

_____

_____

_____

DENTAL QUESTIONAIRE: Please answer to help us serve you

1.) When was your last exam? _____

2.) When was your last cleaning? _____

3.) Are you having pain or discomfort at this time? YES NO

4.) Do your gums bleed when you brush? YES NO

5.) Are you happy with your smile? YES NO

6.) Are you interested in whitening your teeth? YES NO

7.) Are you interested in straightening your teeth? YES NO

8.) Are you interested in invisible braces? YES NO

9.) Have you been told you grind your teeth at night? YES NO

10.) Have you been diagnosed with TMJ problems? YES NO

11.) Are you concerned with bad breath? YES NO

12.) Are you frequently experiencing a dry mouth? YES NO

Comments_____