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.

Who is your family doctor? _____

Have you ever been hospitalized or had a major operation? ❑Yes ❑No **If Yes:** _____

Have you ever had a serious head or neck injury? ❑Yes ❑No **If Yes:** _____

Are you taking any medications, pills or drugs? ❑Yes ❑No **If Yes:** _____

Do you take, or have you taken Phen-Fen or Redux? ❑Yes ❑No **If Yes:** _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑Yes ❑No **If Yes:** _____

Are you on a special diet? ❑Yes ❑No **If Yes:** _____

Do you use tobacco? ❑Yes ❑No **If Yes:** _____

Do you use controlled substances? ❑Yes ❑No **If Yes:** _____

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

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

Other? ❑Yes ❑No **If Yes:** _____

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

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

Have you ever had any serious illness not listed above? ❑Yes ❑No **If Yes:** _____

Do you wear a C-Pap machine or have sleep apnea? ❑Yes ❑No **If Yes:** _____

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:

X _____ **Date:** _____

REGISTRATION FORM

Name (first) _____ (middle initial) _____ (last) _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Social Security# _____

Telephone (home) _____ (work) _____ Birthdate _____ Sex _____

(cell) _____ (e-mail) _____

___Single ___Married ___Widowed ___Divorced

Employed By _____

If Self-Employed, Name of Business/Address _____

Employer's Address _____

How did you learn about our office? _____

Hobbies/Interests _____

Spouse's Name _____ Spouse's Social Security # _____

Occupation of Spouse _____ Spouse's Work Phone _____

Spouse's Birthdate _____ Name of Spouse's Employer _____

Spouse's Employer's Address _____

Person to notify in an emergency (not at home address) _____ Phone _____

Dental Insurance Information

Insured is ___Self ___Husband ___Wife ___Mother ___Father

Employee's Name _____ Employee's Social Security # _____

Employee's Date of Birth _____ Contract ID # _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Are you covered by a second insurance company? ___ Yes ___ No

If yes, name of 2nd insurance co. _____ Group # _____

Employee Name for 2nd ins. _____SSN for 2nd ins. _____

Employee Birthdate for 2nd ins. co. _____ Contract ID # _____

Must Complete if Under 18 or Full-time Student/Responsibility Party Information Required

Mother's Name _____ Mother's Social Security # _____

Mother's Address _____

Mother's Home Phone # _____ Birthdate _____

Mother's Employer _____ Occupation _____ Work Phone _____

Father's Name _____ Father's Social Security # _____

Father's Address _____

Father's Home Phone # _____ Birthdate _____

Father's Employer _____ Occupation _____ Work Phone _____

Please turn the page!

Highlands Point Dental, LLC

Patient's name: _____

I understand that as a service to me, Highlands Point Dental, LLC will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety. This office quotes current fees that are within the usual and customary range of dental services in our area, while many insurances companies pay from a set fee schedule. I understand that Highlands Point Dental, LLC is required by law to maintain the privacy to my protected health information and to provide me with notice of their legal duties and privacy practices with respect to protected health information.

X _____ **Date** _____

Signed *(patient or parent if minor)*

Please list the name (and relationship to you) of any person(s) with whom we can discuss your dental condition/diagnosis:

_____

_____

Only if you have insurance:

So that you don't have to sign an insurance form at each dental visit, Highlands Point Dental, LLC will maintain this "signature on file" for you.

Authorization to Release Information: I hereby authorize any Provider, insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____ **Date** _____

Signed *(patient or parent if minor)*

Authorization to Pay Benefits to below named Dentist: Where applicable, I hereby authorize payment to Highlands Point Dental, LLC for services rendered.

X _____ **Date** _____

Signed *(patient or parent if minor)*