# PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

Patient is : □ Responsible Party □ Policy Holder

**Patient Information:**

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

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

Birth date: Social Security: Drivers Lic:

E-mail:

□ I would like to receive email correspondence □ I would like to receive text messages

**Patient Information (section 2):**

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Pharmacy:

Referred By:

**Responsible Party:** ( **if** other than patient ) ○ Responsible Party is Policy Holder for Patient

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security: Drivers Lic:

**Insurance Information:** Patient's Relationship to Policy Holder: ○Self ○Spouse ○Child ○ Other

Name of Policy Holder Birth date:

Policy Holder Social Security:

Employer: Insurance Company:

Phone: Phone:

Address: Address:

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

Insured ID: Group NO:

# 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? 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: _____
(please list all meds or bring list with you) _____
_____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? (includes beer or wine) Ye s No
Do you need to pre-medicate? Yes No If yes, please explain: _____

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 Acrylic Metal Latex Local Anesthetics

Other even food: If yes, please explain:

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

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

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

## Michael R. Grier, DDS, INC.

### CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Person (if different from patient) Giving Consent:_____
Relationship _____

**Patient Name:**
**Address:**
**Telephone:**
**SSN:**

**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, patient photos, video/surveillance, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether sign 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, and of other important matters about your protected health information. A copy of our 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 our office:

901 S. 3rd Street
Grandview, Texas 76050
(817) 866-2065

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 form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: Date: