PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Social Security No. ______________________

Name: _________________________________ __________________________________ ___

LAST FIRST MI

Mailing Address: __________________________ City: ___________________ St: ________ Zip: ________

Home Phone: (_____) ______-_______ Cell Phone: (_____) ______-________

Preferred Name: __________________ Date of Birth: _______________ Gender: ☐ Male ☐ Female

Race: ______________ Preferred Language: ________________ Email Address:_______________________

Preferred Pharmacy: ____

Primary Insurance Holder Information:

Name of Policy Holder: __________________________ Employer of Policy Holder___________________________

Dental Insurance_________________________

Date of Birth: ___________________________ Social Security No. ______________________

Group ID #: ____________________________ Member ID #: _____________________________

Medical History

Patient Name: ___________________________________ Date of Birth: ________________________

Emergency Contact/ Relationship: __________________________ Emergency contact phone: ___________________

Are you under a physician's care now ☐ Yes ☐ No

Physician's Name: _____________________________ Physician's Phone: (_____) ______-________

Physician Address: _____________________________ City_________________ St _______ Zip___________

Date of last physical exam: ____________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No

If yes, what was the illness or problem? ____

Women Only: Are you pregnant? ☐ Yes ☐ No Number of weeks: ___________________

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement?

☐ Yes ☐ No

If yes, date of surgery: ____________________________________

Any complications? ____

Diseases and Conditions- Please mark Yes or No if you have had any of the following:

	YES	NO
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
HIV/AIDS	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in the last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Fainting spells or seizures	☐	☐
Kidney Problems	☐	☐
Osteoporosis	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐

	YES	NO
Cancer/Chemotherapy/Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐

Please list all current prescription or over the counter medicine/vitamin (s):

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Please mark Yes or No if you had any of the following allergies or reactions to: *

	YES	NO
Local Anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other Antibiotics	☐	☐
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐

Dental History

Reason for today's visit: ____ Are you in pain? ☐ Yes ☐ No

Former Dentist: ____ Date of last dental visit: _______________________

Date of last dental x-rays:___________________

Diseases and Conditions- Please mark Yes or No if you had any of the following: *

	YES	NO		YES	NO
Bad Breath	☐	☐	Sores or growths in our mouth	☐	☐
Bleeding gums	☐	☐	Periodontal treatment	☐	☐
Blisters on lips or mouth	☐	☐	Pain around ear	☐	☐
Burning sensation of tongue	☐	☐	Sensitivity to cold	☐	☐
Dry mouth	☐	☐	Sensitivity to heat	☐	☐
Gums swollen or tender	☐	☐	Sensitivity to sweats	☐	☐
Loose teeth or broken fillings	☐	☐	Jaw pain	☐	☐

Do you use tobacco (smoking, snuff, chew)? ☐ Yes ☐ No
If yes, are you interested in stopping: ☐ Yes ☐ No

I understand the above information and attest that this information is accurate and complete to the best of my knowledge.

Signature ____ Date _____________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Date: ________________________

Name: _________________________________ _______________________________

LAST FIRST

Birthdate: ______________________

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;

• To obtain payment from third-party payers;

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____ Date: ___________________

815 S. Pine St. Vivian, LA. Cristin Jackson, DMD 318-375-3183