PATIENT REGISTRATION

Today's date ____/____/____

Name: Dr/Mr/Mrs/Ms _____ ☐Male ☐Female

Address: _____ City_____State_____Zip_____

DOB: _____ SS# _____

Home Phone: _____ Work: _____ Cell: _____

Email:_____

Whom may we thank for referring you to us? _____ Relationship to you:_____

List any other family members who come to our office? _____

Person to contact in case of an emergency _____ Phone: _____

Person financially responsible _____ Relationship to you:_____

Address: _____

City: _____ State: _____ Zip _____ Phone: _____

Dental Insurance Information

Insurance Company: _____ Who is the insurance through? ☐Self ☐Spouse

Spouse full name: _____ Spouse DOB: _____

Subscriber/MemberID#: _____ Group#:_____

Employer: _____
(Please provide insurance card)

Dental History

Are you presently in any discomfort? ☐Yes ☐ No If yes, describe _____
Do you have any dental fears? ☐Yes ☐ No If yes, describe _____
Are you dissatisfied with your teeth & their appearance? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Does anyone in your family have gum disease? ☐Yes ☐ No
Do your gums bleed when you brush? ☐Yes ☐ No
Do you have swelling around any teeth? ☐ Yes ☐ No
Do you notice a bad taste or odor? ☐ Yes ☐ No
Are your teeth sensitive to (check all that apply) ☐ hot ☐ cold ☐ sweet ☐ biting pressure
Have you noticed any jaw problems like: ☐ clicking ☐ pain ☐ chewing ☐ opening ☐ closing
Are you concerned about the finances required to return your teeth to excellent dental health? ☐ Yes ☐ No
Do you get frustrated because you always need something to be treated or repaired at the dentist? ☐ Yes ☐ No
Why did you leave your last dentist? _____

Medical History

Physician's Name _____Phone ( ) _____

Date of your last physical exam? _____

Please list current Medications _____

Do you have any allergies to medications? ☐Yes ☐No If yes, what? _____

Have you been a patient in a hospital in the past five years? ☐Yes ☐No Please Explain _____

Have you ever had any surgeries? ☐Yes ☐No Please List _____

Have you had or do you have any of the following:

	YES	NO		YES	NO
Heart (Surgery, Disease, Attack)	☐Yes	☐No	Substance Abuse	☐Yes	☐No
Heart Pacemaker/ Defibrillator	☐Yes	☐No	Ulcers	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Stroke / TIA	☐Yes	☐No	Diabetes	☐Yes	☐No
History of Endocarditis	☐Yes	☐No	Glaucoma	☐Yes	☐No
Artificial Joints (hip, knee etc.)	☐Yes	☐No	Asthma	☐Yes	☐No
Arthritis/Rheumatism or swelling of joints	☐Yes	☐No	Latex Sensitivity	☐Yes	☐No
Kidney Disease	☐Yes	☐No	Allergies or Hives	☐Yes	☐No
Bone Density Drugs, Osteoporosis	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Sexually Transmitted Disease	☐Yes	☐No	Radiation Therapy, Chemotherapy	☐Yes	☐No
Cold Sores/Fever Blisters	☐Yes	☐No	Cancer, Tumor	☐Yes	☐No
AIDS,HIV	☐Yes	☐No	Tobacco Use	☐Yes	☐No
Sleep Apnea	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No
Hemophilia, Bleeding problems	☐Yes	☐No	Psychiatric/Psychological Care	☐Yes	☐No
Liver Disease	☐Yes	☐No	Dizziness, Fainting, Vertigo	☐Yes	☐No
Hepatitis A, B, or C	☐Yes	☐No	Cosmetic Surgery	☐Yes	☐No

Women Only: Are you pregnant? ☐Yes ☐No If yes, Due date? _____

Are you taking birth control pills? ☐Yes ☐No

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

Please explain: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any change in my health or medication.

*Address*_____*City*_____*State*_____*Zip*_____

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon myself and to employ such assistance as required to provide proper care.

Signature _____ Date_____

Witness_____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Noble Dental / Drs. Conover & Leonard may use or disclose your health care information.

The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though this office has taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice.

Signing below indicates that you have received the Notice of privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer.

I hereby acknowledge that I have received a copy of the Office's Notice of Privacy Practices.

NAME (Please Print) _____

SIGNATURE _____

DATE _____

Office Policy

Appointments are made and reserved especially for you. In the event you may need to reschedule an appointment we kindly ask that you give us at least 48 hours notice to cancel that appointment.

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. Date:
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify below)