CONFIDENTIAL

# Patient Registration Information

Date _____ Patient # _____

Name _____
First MI Last

Whom may we thank for referring you? _____

Home address _____ City _____ State/Prov. _____ Zip/P.C. _____

Birthdate _____ Social Security: _____ DL#/ID: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell

## Emergency Contact Information

Name _____ Phone #: _____ Relationship: _____

Name _____ Phone #: _____ Relationship: _____

## Primary Insurance Information DENTAL ONLY

Primary Holder's Name:
First MI Last

Address:

Phone #:

Social Security #:

Date of Birth:

Employer:

Insurance Co:

Address:

Group #:

Policy #:

## Secondary Insurance Information DENTAL ONLY

Secondary Holder's Name:
First MI Last

Address:

Phone #:

Social Security #:

Date of Birth:

Employer:

Insurance Co:

Address:

Group #:

Policy #:

## Responsible Party (ONLY TO BE COMPLETED IF PATIENT IS UNDER 21)

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City _____ State/Prov. _____ Zip/P.C. _____ SS #/SIN _____

Driver's license # _____ Birthdate _____ Contact # _____

Please Continue... ☞

## Authorization for Release of Treatment and/or Financial Information

**I authorize Dr. Noonan, Jr., D.M.D. to release the following Information to the following person/people.**

_____ Treatment _____ Financial _____
**NAME / RELATIONSHIP** **INITIAL** **INITIAL**

_____ Treatment _____ Financial _____
**NAME / RELATIONSHIP** **INITIAL** **INITIAL**

_____ Treatment _____ Financial _____
**NAME / RELATIONSHIP** **INITIAL** **INITIAL**

# 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.

_____
Signature

## Authorization, Release, and Agreement to Pay For Services Rendered

**I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.**

**I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.**

**I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.**

**X** _____ _____
**Signature of patient or parent/guardian if minor** **Date**

**Late Charges**

**If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.**

**Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.**

**PATIENT NAME** _____ **PATIENT #:** _____

**HOME ADDRESS** _____ **HOME PHONE:** _____

_____ **WORK PHONE:** _____

**EMPLOYER:** _____ **CELL PHONE:** _____

**SS#:** _____ **DATE OF BIRTH:** _____

## PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

| | YES | NO |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |

If yes, what medication(s) are you taking? _____

_____

_____

_____

4. Are you allergic to or have you had any reactions to the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Local anesthetics (e.g. novocaine) | ☐ | ☐ | Barbiturates | ☐ | ☐ | Aspirin |
| ☐ | ☐ | Penicillin or other antibiotics | ☐ | ☐ | Sedatives | ☐ | ☐ | Latex/Rubber |
| ☐ | ☐ | Sulfa Drugs | ☐ | ☐ | Iodine | | | Other: _____ |

5. WOMEN ONLY:

| | YES | NO |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking birth control pills? | ☐ | ☐ |

6. Do you have or have you had any of the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Attack | ☐ | ☐ | Diabetes | ☐ | ☐ | Stomach Troubles / Ulcers |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice |
| ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | AIDS or HIV Infection | ☐ | ☐ | Easily Winded |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Thyroid Problem | ☐ | ☐ | Stroke |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Hay Fever / Allergies |
| ☐ | ☐ | Angina | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Swollen Ankles | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Fainting / Seizures | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Asthma | ☐ | ☐ | Cancer | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low/High Blood Pressure | ☐ | ☐ | Arthritis | ☐ | ☐ | Respiratory Problems |
| ☐ | ☐ | Epilepsy / Convulsions | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Other _____ |
| ☐ | ☐ | Leukemia | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | _____ |

| | Yes | No | |
|---|---|---|---|
| 7. | ☐ | ☐ | Do you use tobacco? |
| 8. | ☐ | ☐ | Do you use controlled substances? |
| 9. | ☐ | ☐ | Do you use cocaine? |
| 10. | ☐ | ☐ | Do you use alcohol? |

**MEDICAL HISTORY UPDATE:**

DATE: INITIALS:

_____

_____

_____

_____

## PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking? | ☐ | ☐ |
| b) Pain (joint, ear, side of face)? | ☐ | ☐ |
| c) Difficulty in opening or closing? | ☐ | ☐ |
| d) Difficulty in chewing? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 7. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 8. Do you clench or grind your teeth? | ☐ | ☐ |
| 9. Have you had any orthodontic treatment? | ☐ | ☐ |
| 10. Have you ever had prolonged bleeding following extractions? | ☐ | ☐ |
| 11. Have you ever had instruction on the correct method of brushing your teeth? | ☐ | ☐ |
| 12. Have you ever had instructions on the care of your gums? | ☐ | ☐ |

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

**SIGNATURE** X _____ _____

PATIENT, PARENT OR GUARDIAN TODAY'S DATE