IDEAL DENTAL

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
* Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____

Business Address _____ Business Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves or Joints, Screws, etc
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Diabetes
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands
☐ Ulcer
☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time?_____ If so, what?_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Parent, Guardian or Personal Representative | Relationship to Patient

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

_____ _____

Date | Patient Signature

_____ _____

Date | Dentist Signature

APPENDIX C

Ideal Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received
(Name of Patient)

a copy of Ideal Dental's Notice of Privacy Practices. This Notice describes how Ideal Dental may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative) (Date)

(Relationship to Patient)