

REGISTRATION AND HEALTH HISTORY

Patient Information (please print):

Last Name _____ First Name _____ Middle Initial _____

Nickname _____ Patient's Date of Birth ____ / ____ / ____ Age Male Female

*If this appointment is for your child, your name _____

Patient's Address _____ City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Personal E-mail Address _____ Work E-mail Address _____

Employed by _____ How long? _____ Occupation _____

Marital Status (check one) Single Married Divorced Widowed

Spouse's Last Name _____ First Name _____ Middle Initial _____

Spouse's Date of Birth ____ / ____ / ____ Social Security # _____ Or ID _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Personal E-mail Address _____ Work E-mail Address _____

Employed by _____ How long? _____ Occupation _____

DENTAL INSURANCE INFORMATION

Please provide us with your insurance card to copy for your file.
We are happy to assist you in filing your insurance; however, you are responsible for your account balance.

Primary Insurance Information (please print)

Subscriber's Last Name _____ First Name _____ Middle Initial _____

Patient's Relationship to Subscriber (check one) Self Spouse Child Other _____

Subscriber's Social Security # ____ / ____ / ____ Subscriber's Date of Birth ____ / ____ / ____

Subscriber's Address _____ City _____ State _____ Zip _____

Name of Employer _____ Group# _____ ID # _____

Insurance Company & Mailing Address _____

City _____ State _____ Zip _____ Phone (____) ____ - ____

Secondary Insurance Information (please print)

Subscriber's Last Name _____ First Name _____ Middle Initial _____

Patient's Relationship to Subscriber (check one) Self Spouse Child Other _____

Subscriber's Social Security # ____ / ____ / ____ Subscriber's Date of Birth ____ / ____ / ____

Subscriber's Address _____ City _____ State _____ Zip _____

Name of Employer _____ Group# _____ ID # _____

Insurance Company & Mailing Address _____

City _____ State _____ Zip _____ Phone (____) ____ - ____

ACCOUNT INFORMATION

Person Financially Responsible for Account _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Emergency Contact Person _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

How did you hear about our office (referral)? Radio Internet Family/Friend Yellow Pages Dr. Referral

Other _____

(OVER)

DENTAL HISTORY

1. Who was your former dentist? Name _____
City _____ State _____ Zip _____ Phone (____) _____ - _____
2. When was your last dental treatment? ____/____/____ Type of Treatment _____
3. Are you having pain or discomfort at this time? YES NO Where? _____
4. How would you describe your present dental health? Good Fair Poor
5. Have you experienced any unfavorable reaction to any previous dental treatment
(anesthetic reaction, pain, other)? YES NO
6. Are you satisfied with your tooth appearance? YES NO
7. Are you satisfied with your tooth color? YES NO
8. Do you feel your teeth are: Crowded? Poorly Aligned? Protruding?
9. Do you have fractures in your front teeth? YES NO
10. Are you hiding your teeth while smiling? YES NO

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? YES NO
 2. Have you been under the care of a medical doctor during the past two years? YES NO
 3. Have you taken any medicine or drugs during the past two years? YES NO
If yes, please list _____
 4. Do you take any of the following bisphosphonates such as? Fosamax Actonel Resclast
 Other _____
 5. Are you aware of being allergic to any medications, latex, or substances? YES NO
If yes, please list _____
 6. Please check if you have ever used any of the following substances? Tobacco/Frequency _____
 Alcohol/Frequency _____
 7. Preferred Pharmacy: _____
 8. Check any of the following which you have had or have at present:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Fainting
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Headaches
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	• persistent cough	<input type="checkbox"/> Sickle Cell Diseases
<input type="checkbox"/> A.I.D.S.	• bloody sputum	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Hepatitis A (infectious)	• anorexia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hepatitis B (serum)	• fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> H.I.V.	<input type="checkbox"/> Ulcers	
- FOR WOMEN ONLY:
- Are you pregnant? YES NO If yes, what month? _____
- Are you taking birth control pills? YES NO
9. Do you have any disease, condition or problems not listed? If yes, please list: _____

Consent:

The undersigned acknowledges reading the Informed Consent form and hereby authorizes the Practice to take radio-graphs, photographs, or study models, and to use any other diagnostic aids deemed appropriate for accurate diagnosis of the patient's dental needs. I also authorize the Practice to perform any and all forms of treatment, medication and therapy that may be indicated. Further, I understand the responsibility of payment for dental services provided to my dependents and myself is due and payable at the time service is rendered. Having received and read the Practice Notice of Privacy, I authorize the use and disclosure of this information for the purposes of treatment, payment, dental care, and referral.

Patient: _____ Date: ____ / ____ / ____

Parent/Responsible Party _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

Armstrong & Eshleman, P.A. is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of Armstrong & Eshleman's, P.A. Notice of Privacy Practices. Also, I acknowledge that I have read and understand the Information and Consent form on the back of this page and initialed the back page.

Please print your name here: _____

Signature: _____

Date: _____

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

HIPAA Acknowledgment of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.