Patient Registration

Patient Information:

Name:__________ Birthdate__________ Social Security #__________

Address__________ City__________ Zip__________ Home Phone__________

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer__________ Occupation__________

Work Phone__________ Cell Phone__________ Email__________

Spouse__________ Birthdate__________ Social Security #__________

Employer__________ Occupation__________

Work Phone__________ Cell Phone__________ Email__________

If patient is a minor, please complete the following:

Name of person responsible for this account__________ Relationship to patient__________

Address__________ City__________ Zip__________ Home Phone__________

Birthdate__________ Social Security #__________

Employer__________ Occupation__________ Work Phone__________

General Information:

Who may we thank for referring you? __________

Previous Dentist Name__________ Phone__________

____

Patient's Physician__________ Address__________ Phone__________

Emergency Contact__________ Address__________ Phone__________

Insurance Information:

Primary Coverage:	Secondary Coverage:
Insurance Company__________	Insurance Company__________
Claims Address__________	Claims Address__________
Policy Holder__________	Policy Holder__________
Birthdate__________ Social Security #__________	Birthdate__________ Social Security #__________
Birthdate__________ Group #__________	Employer__________ Group #__________

We would like to introduce you to our Smile Reminder™ program.

Smile Reminder™ is a way that we can make it easier for you to remember your appointment by sending you reminders via text messages to your cell phone, pager, e-mail or PDA. It's benefits include being able to read the messages at your time is valuable and it's sometimes challenging to receive our calls.

If this is not something you are interested in please let us know and we will send your confirmations via mail.

Smile Reminder™
Patient Contact Information

Name:__________

Cell:__________

Email:__________

Pager:__________

Name______________________________ Date________________

Medical History and Questionnaire

Do you have, or have you had, any of the following? Please check all that apply.

Congestive Heart Failure________ ☐
Shortness of breath________ ☐
Blood pressure problem________ ☐
☐High ☐Low
Heart murmur________ ☐
Rheumatic fever________ ☐
Pacemaker________ ☐
Artificial heart valve/type________ ☐
Premed required/type________ ☐
☐Yes ☐No
Premed with:
Easy bruising/abnormal bleeding (circle one)____ ☐
Frequent nose bleeds________ ☐
Blood disease (anemia)________ ☐
Blood transfusion________ ☐
Blood thinner/daily aspirin (circle one)________ ☐
History of stroke or TIA (circle one)________ ☐
Seasonal allergies________ ☐
Sinus problems________ ☐
Asthma________ ☐
Tuberculosis, COPD (circle one)________ ☐
Hepatitis, type:________ ☐
Liver problems________ ☐
Ulcers________ ☐
Kidney problems________ ☐
Bladder problems________ ☐
Gallstones/gallbladder problems (circle one)____ ☐
Kidney or bladder problems________ ☐
Osteoporosis or osteopenia (circle one)________ ☐
Arthritis________ ☐
Back/neck pain (circle one)________ ☐
Joint replacement________ ☐
Type:________
Premed required/type________
____

Do you take or have you taken any of these medications?
☐Etidronate (Didronel) ☐Clodronate (Bonefos, Loron)
☐Tiludronate (Skelid) ☐Pamidronate (Aredia)
☐Neridronate ☐Olpadronate
☐Alendronate (Fosamax)
☐Ibandronate (Bondronate/Boniva)
☐Risendronate (Actonel)
☐Zolendronate (Zometa)

Fainting Spells, Seizures, or Epilepsy (circle one)________ ☐
History of head trauma________ ☐
Frequent/severe headaches/migraines (circle one)________ ☐
Do you take antidepressants?________ ☐Yes ☐No
Thyroid concerns________ ☐
Diabetes/Type________ ☐
Date of most recent hA1c________ ☐
Urinate more than 6 times per day________ ☐
Thirst/dry mouth (circle one)________ ☐
Family history of diabetes________ ☐
Do you smoke/how much________ ☐
Do you use smokeless tobacco/how much________ ☐
Herpes/other STD (circle one)________ ☐
HIV+/Aids (circle one)________ ☐
History of alcohol abuse________ ☐
Are you an organ donor/recipient?________ ☐Yes ☐No
Other disease not listed________ ☐
List all meds you take and for what________
____
____
____
____
____
____
____
____
____
List all allergies/symptoms________
____
____

Women:
Pregnant/due date________
Are you nursing?________ ☐Yes ☐No
Contraceptives/other hormones (circle one)________ ☐

Men:
Do you take medications for erectile dysfunction? ____ ☐Yes ☐No
Do you have a history of prostate cancer?________ ☐Yes ☐No
Other comments________
____
____
Is there anything else you would like to discuss with us? ________
____
____

Dental History and Questionnaire

What is your estimation of your dental health? ❑Excellent ❑Good ❑Fair ❑Poor

Is your mouth comfortable now? ❑Yes ❑No

If no, please describe the discomfort or problem: ______________________________

____

____

Do you have any active dental disease in your mouth that you are aware of? ❑Yes ❑No

How long have you been with your present general dentist? ______________________________

How much dentistry has been performed on your mouth this year? ______________________________

Do any members of your family presently have or have they had in the past: (Please list relationship to you):

❑Dentures ______________________________

❑Periodontal Disease ______________________________

Are you satisfied with the appearance of your teeth? ❑Yes ❑No

What would the loss of your natural teeth mean to you? ______________________________

____

What are your goals and expectations of periodontal therapy? ______________________________

____

____

____

Have you had any serious trouble associated with a previous dental experience? Please specify. ______________________________

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____

Please list any other comments regarding your teeth, mouth, or dental history: ______________________________

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I authorize the release of my dental records from Drs. Culberson, Mulliken or Rutherford to individuals involved in my dental care. I further authorize the release of records from any individuals to Drs. Culberson, Mulliken or Rutherford,

I authorize insurance payments to be made directly to Drs. Culberson, Mulliken or Rutherford. I understand that I am responsible for any unpaid balance.

I am aware that should I not provide adequate notice to change an appointment, I may be charged a fee. (7 business days for a surgical appointment and 2 business days for a cleaning appointment).

I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you may access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

AUTHORIZATION FOR APPOINTMENT CONFIRMATION

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, and voicemail messages. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize the offices of Drs. Culberson, Mulliken or Rutherford and their staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Patient's Signature____ **Date**__________

Parent or Guardian (If Patient is a Minor)____________________________ **Date**__________

This form will be retained in your dental record.