

Patient Registration Form

First Name: _____ Last Name: _____ Middle Initial: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Who may we thank for referring you to our practice: _____

Patient Information

Street Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Social Security number: _____

Cell phone #: _____ Home phone #: _____ Work phone #: _____

Email: _____

How would you prefer to receive appointment confirmations: Text: _____ Email: _____ Phone call: _____

Primary Dental Insurance Information

Name of policy holder: _____ DOB: _____

Policy holder SSN: _____ Relationship to policy holder: **0 self 0 spouse 0 child 0 other**

Name of employer: _____ Name of dental insurance: _____

ID# for insurance: _____ Secondary insurance: YES: _____ NO: _____

Informed Consent Form

I do hereby authorize and consent to any x-rays, examination, prophylaxis (dental cleaning), non-surgical treatment of the gums, anesthetic, restorations, oral photographs, emergency services, or dental treatment rendered under the general, direct or indirect supervision of Dr. Brien Hedstrom and his staff members, as they may deem necessary to create a better health for my mouth. I understand that during treatment, un-foreseen conditions may arise which may necessitate procedures different than those discussed prior to treatment. I therefore consent to the performance of any additional treatment which Dr. Brien Hedstrom considers necessary. I understand that some after treatment effect and complications do occur with regularity. I understand that it is vital that I give as accurate and complete medical and personal history as possible, follow any and all instructions and permit to prescribed diagnostic procedures. Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help ensure the best possible result. My signature below confirms that I understand that no dental treatment is completely risk free and that my dentist will take all reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

Signature: _____ Date: _____

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X Date: _____

HIPPA OMNIBUS RULE

Patient acknowledgement of receipt of notice of privacy practice's and consent/limited authorization and release form.

**You may refuse to sign this acknowledgement, in refusing we may not be allowed to process your insurance claims.*

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

Date: _____

Please print your name

Please sign your name

Legal representative

Description of authority

Please list any other parties who can have access to your health information: (this includes step parents, grandparents and any other care taker who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize this office may recommend products or service to promote your improved health. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only: As privacy offer, I attempted to obtain the patient's (or representatives) signature or this acknowledgement but did not because:

It was emergency treatment: _____

I could not communicate with patient: _____

The patient refused to sign: _____

The patient was unable to sign because: _____