New Patient Registration

Patient's Full Name (First, M, Last): _____

Date of Birth: ____/____/____ Social Security # (Dental Ins Only): _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Sex: Male / Female Marital Status: _____

Work Phone: (_____) _____-_____ Whom may we thank for referring you?

Home Phone: (_____) _____-_____ _____

Email (used ONLY for Treatment Reports sent after procedure):_____

Primary Dental Insurance Coverage

Account-holder Name: _____

Relation to Patient: _____ SS#: _____-_____-_____ DOB: ____/____/____

Employer Name: _____

Insurance Company: _____ Phone #: (_____) _____-_____

Address: _____

Member ID: _____ Group/Plan #: _____

Secondary Dental Insurance Coverage

Account-holder Name: _____

Relation to Patient: _____ SS#: _____-_____-_____ DOB: ____/____/____

Employer Name: _____

Insurance Company:_____ Phone #: (_____) _____-_____

Member ID: _____ Group/Plan #: _____

Emergency Contact and/or Party Financially Responsible for Patient

Name: _____Phone #: (_____) _____-_____

Address: _____

Signature SPECIALISTS
WYATT D. SIMONS, DDS, PC
SPECIALIST OF ENDODONTICS

Patient Medical History

Patients Name: _____

Physicians (MD) Name: _____ _____

Has there been any change in your general health within the last year (CIRCLE)? **YES or NO**

If YES, what is the condition being treated? _____

Are you taking or have you ever taken Fosamax, or any other bisphosphonates? _____

(**Bisphosphonates** are a class of drugs that prevent the loss of bone density, used to treat osteoporosis and similar diseases)

Please list any prescription medications: _____

_____

Please list any known allergies: _____

Do you smoke or use any type of tobacco products (CIRCLE)? **YES or NO**

Please list PHARMACY name and City: _____

Health History

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Emphysema	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Fever Blisters	☐	☐	Psychiatric Problems
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Radiation Treatment
☐	☐	Artificial Joints	☐	☐	Heart Attack or Surgery	☐	☐	Rheumatic Fever
☐	☐	Arthritis	☐	☐	Headaches	☐	☐	Shingles
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Sickle Cell Disease
☐	☐	Cardiovascular Disease	☐	☐	Hepatitis **A or B or C**	☐	☐	Sinus Problems
☐	☐	Common Allergies	☐	☐	Herpes	☐	☐	Tuberculosis
☐	☐	Congenital Heart Defect	☐	☐	HIV+/AIDS			Active (circle)_____
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Ulcers/Colitis
☐	☐	Difficulty Breathing	☐	☐	Low **or** High BP **(circle)**	☐	☐	Yellow Jaundice
☐	☐	Drug **or** Alcohol Abuse	☐	☐	Mitral Valve Prolapse			

Yes	No	
☐	☐	Do you have any disease, condition/ additional details, or problem not listed above that you think we should know about? If yes, please explain: _____ _____
☐	☐	Do you require antibiotics before dental treatment? Compared with previous recommendations, there are currently relatively few patients for whom antibiotic prophylaxis may be indicated prior to certain dental procedures.

Patient Signature: _____ Date: _____

For Women Only…

Yes	No	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? # of weeks: _____
☐	☐	Are you nursing?

Doctor Only: I verbally reviewed medical history/dental information above with patient.

Signature: _____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, _____ from
Name of Staff Member
this practice has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices." For example: If the patient changes the context of the Privacy Practices, such as changing how the referring doctor obtains the results of treatment ie: certified mail only, the practice is not required to honor that specific request.

_____ _____

Patient Signature **Date**

_____

Patient Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

As privacy officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because: (Describe) Emergency treatment, could not communicate with the patient, patient refused to sign, the patient was unable to sign because (explain)

_____

_____

_____

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