Date_____ Referring Dentist_____

REGISTRATION

Name _____

Circle One Mr. Mrs. Ms.Miss Military Rank_____

Address_____

_____State_____Zip_____

Telephone # _____ Name _____

Cell# _____ Phone _____

Of driver if needed

Employer_____

Address _____State_____Zip_____

Telephone# _____

Occupation _____

S.S.# _____

D.O.B. _____

Name of Person Responsible for Account_____

Name of Dental Insurance_____Account#_____

Name of Medical Insurance_____Account#_____

Subscribers D.O.B. _____ Employer_____

Today's Visit Paid By: Cirlce One VISA M/C AMEX DISCOVER CASH CHECK

OTHER_____

ASA_____

Robert A. Goodwin, Jr., DMD
Oral & Maxillofacial Surgery

Medical History

Date_____

Name _____
(last) (first) (middle)
Age ___ **Date of Birth** ___/___/___ **Sex** ___ **Height** _____ **Weight** _____
Referred by _____ **Address**_____
Dentist _____ **Address**_____
Physician _____ **Address**_____

1. **What is the main problem with your mouth? Please circle below.**
   A) pain? Yes No
   B) swelling? Yes No
   C) location? upper lower right side left side
2. **Date of last physical exam** ___/___/___
3. **Are you in good health? If there have been any changes in your health in the past year, please explain.** _____ **Yes No**
   _____
4. **Are you allergic to any medications, food, latex,** eggs other **substances (E.g. penicillin, codeine, or local anesthetics like Novocaine/Lidocaine)? If yes, please list.** _____ **Yes No**
   _____
5. **Are you taking any medications or drugs? If yes, please list the name of the medication.** _____ **Yes No**
   _____
6. **Do you have, or have you had any of the following conditions?**

   Nervous system
   a) epilepsy, seizures or loss of consciousness? **Yes No**
   b) numbness of the face, mouth or tongue? **Yes No**

   Circulatory system
   a) heart attack, stroke, or any heart disease? **Yes No**
   b) "angina" or pain in the chest, face or arms with exertion or at rest? **Yes No**
   c) high or low blood pressure? (please circle which) **Yes No**
   d) rheumatic fever, heart murmur, or mitral valve prolapse? **Yes No**
   e) any kind of heart surgery? **Yes No**

   Blood system
   a) blood disorder (E.g. anemia, leukemia, hemophilia, Von Willibrand's disease? **Yes No**
   b) blood transfusion? **Yes No**

Robert A. Goodwin, Jr., DMD
{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ XXXXX _____

XXXXX: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Nancy or Danielle

Telephone: (732) 458-8100 Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.