

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name — Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____/____/____

In front of _____
Printed Name — Practice Representative

REGISTRATION FORM

Section I:	Patient Information	Date
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip: _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Patient: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	

Section III	Insurance Information
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING -----	
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	

Your Personal Health History:

Welcome. As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Complete disclosure of your health information is vital for your health and safety. Your information is typically used to process insurance claims, provide medical or dental information to professionals involved in your care, and to facilities such as hospitals in which you may be treated. A copy of our HIPPA policy is available upon request.

Name

Dental Information:

Please provide the name of your dentist and the names of any dental specialists involved in your care.

Why are you here to be seen by Dr. Wible today?

Have you recently had, or are you having, any pain, fever, severe cough or TMJ disorder?

When was your last dental visit? What services or procedures did your receive?

Have you had a problem with dental or medical treatment in the past, such as allergic reaction, fainting or severe anxiety? Please describe here:

Medical Information:

Please provide the name(s) of your medical doctor(s), including specialists involved in your care.

Are you in good health? Has there been any change in your health over the past year?: Date of last examination:

Please list all serious illnesses, operations and recent hospitalizations:

Please list all supplements, prescription and over the counter medications which you are taking or have recently taken:

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: If yes, have you had any complications?			Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED		
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? If yes, how much do you typically drink in a week?		
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began:			WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Allergies - Are you allergic to or have you had a reaction to: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK To all yes responses, specify type of reaction. Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK			Name of physician or dentist making recommendation: Phone:		
Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Please explain:					

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to completion of this form.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments: