NEW PATIENT REGISTRATION

Patient: _____ Preferred Name: _____
Last Name First Name Middle Initial

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

Email Address: _____

The best way to contact me is through: □ Text □ Email □ Cell □ Home □ Work □ No preference

Home Address: _____

City: _____ State: _____ Zip: _____

DOB: _____/_____ /_____ Social Security #:_____ □ Male □ Female / □ Single □ Married
MM DD YYYY

Employer: _____ Spouse Name: _____ Spouse's Employer:_____

Alternate Contact (Outside of Home/Spouse): _____

Who can we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ Address: _____

Method of Payment (After Insurance Payments): □ Cash/Check □ Credit Card □ Third Party Financing

PRIMARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group #_____ ID# _____

SECONDARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group #_____ ID # _____

MEDICAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group #_____ ID # _____

I authorize treatment by Dr._____ and agree to pay all related professional fees. Fees not covered by my dental/medical insurance will be promptly paid upon notification from this office. I have received a copy of the office's financial policy and without reservation I agree to abide by the policies outlined herein.

Signature: _____Date: _____

HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____

Physician's name, phone, and date of last exam: _____

Yes No Do you take medications? If so, please list: _____

_____

Yes No Do you have allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: _____

Yes No Have you been hospitalized? If so, please list dates and reasons: _____

Do you have or have you ever had any of the following (if "Yes", please circle which):

Yes No Artificial joints (hip, knee, etc.)
Yes No High blood pressure / Angina / Arrhythmias
Yes No Heart disease / Heart attack / Defibrillator
Yes No High Cholesterol
Yes No Artificial heart valve / Pacemaker
Yes No Bleeding disorders / Prolonged bleeding
Yes No Anemia / Leukemia / Blood dyscrasias
Yes No Stroke / Aneurysm
Yes No Seizures
Yes No Hepatitis / Liver disease / Kidney problems
Yes No HIV / AIDS
Yes No Ulcers / Stomach problems
Yes No Osteoporosis / Bone disease
Yes No Diabetes / Family History of Diabetes
Yes No Thyroid / Adrenal problems

Yes No Periodontal (gum) disease
Yes No Family history of periodontal disease
Yes No Cancer / Tumors - explain _____
Yes No Chemotherapy / Radiation treatment
Yes No Sinus problems / Ear problems
Yes No Asthma / Tuberculosis / Lung disease
Yes No Arthritis / Lupus
Yes No Anxiety / Depression / Psychiatric treatment
Yes No Dental anxiety
Yes No Sleep Apnea
Yes No TMJ Pain / Disorder
Yes No Tobacco use/e-cigarette/marijuana
Yes No Drug / Alcohol abuse
Yes No Currently Pregnant / Nursing

Yes No Any other medical problems? If so, please describe: _____
Yes No Would you like to discuss sedation options for your dental treatment?
Rate your smile on a scale of 1-10, with 10 being perfect: 1 2 3 4 5 6 7 8 9 10

How often do you: brush your teeth_____ floss your teeth_____

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: _____ Date: _____

Hygienist/Assistant Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Revised: August 1, 2019

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Soundview Dental Arts. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Soundview Dental Arts reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**YES**	**NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**YES**	**NO**
Any Member of my extended family: (Parents, Grandchildren)	**YES**	**NO**
Other:	**YES**	**NO**
Name of patient (please print):		
Patient signature (if 18 years old or older):		
Patient's personal representative: (Please Print):		
Personal Representative's signature:		
Representative's Telephone Number: **Date:**		

FOR OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**YES**	**NO**	**Date Statement Provided:**_____
Reason for not obtaining Patient signature		**Needed more time to review Statement of Privacy Practices**	
		Wanted to consult another person before signing	
		Physically unable to sign	
		No reason offered	
		Other:	