PATIENT REGISTRATION

First Name:_____ **Last Name:**_____ **Middle Initial:**____ **Preferred Name:**_____

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: _____ Work Phone:_____ Ext:_____ Cell Phone:_____ Text: Y / N

Male / Female Single__ Married__ Divorced__ Separated__ Widowed__ Date of Birth: _____ Age:_____ Soc. Sec:_____

E-mail Address:_____ Receives e-mail: Y / N Driver's License:_____ State:_____

Patient is: Policy Holder _____ Responsible Party _____ ✓ Preferred form of communication: Phone H / W / C: _____ Text: _____ E-Mail: _____

Employed By:_____ Present Position:_____ How Long:_____ Retired_____

Referred By:_____ Closest Relative:_____ Phone:_____

Responsible Party: (if different than patient)_____ Relationship:_____ Date of Birth:_____

Address:_____ City:_____ St/Zip:_____ Phone:_____ H /C

Name of Insured:_____ Relationship to insured: __self __spouse __child __other Phone:_____ H /C

Insured Soc. Sec:_____ Insured Birth Date:_____ Insured ID #:_____ Group#_____

Insurance Company:_____ Address:_____

Employer:_____ City:_____ State:_____

Secondary Insurance: Name of Insured:_____ Relationship:_____ Phone:_____ H / C

Insured Soc. Sec:_____ Insured Birth Date:_____ Insured ID #:_____ Group#_____

Insurance Company:_____ Address:_____

Employer:_____ City:_____ State:_____

The information on this sheet front and back must be completed before the doctor will see you. It is important that we know about your dental and medical history. Medical History Form on the reverse side.

Reason for present dental visit:_____

Do you have regular dental check-ups? Yes ____ No ____ Date of last visit to the dentist: _____ Name: _____

Are you under a physician's care? Yes ____ No ____ Physician's Name: _____

Reason: _____ Date of last physical exam: _____

Hospitalizations: _____

Medications: _____

_____

_____

_____

MEDICAL HISTORY

Patient Name:_____ **Today's Date:**_____

Thank you for answering the following questions.

Are you allergic to any of the following? Please circle or list all that apply.

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other: _____

Have you ever taken Bisphosphonates such as Fosamax, Boniva, Actonel, Zometa, etc. for Osteoporosis, Breast Cancer, Multiple Myeloma, Prostate Cancer or other conditions? Yes _____ No _____ Other: _____ Have you taken Xgeva or Prolia? Yes _____ No _____

Do you have or have you had any of the following? Please check if yes.		Initials	Date
_____ Heart Disease, Angina, Valve Replacement, Heart Murmur, Mitral Valve Prolapse, Congenital Heart Disorders, or Pacemaker		_____	_____
_____ Stroke	_____ Sinus Problems / Tonsillitis	_____	_____
_____ High or Low Blood Pressure	_____ Allergies	_____	_____
_____ Rheumatic Fever / Rheumatic Heart Disease	_____ Hepatitis A, B or C or Other Liver Disorders	_____	_____
_____ Anemia or Other Blood Disorder	_____ AIDS / HIV Positive	_____	_____
_____ Excessive Bleeding After Tooth Extraction	_____ Venereal Disease (VD), Sexually Transmitted Disease (STD)	_____	_____
_____ Tuberculosis	_____ Oral Contraceptives	_____	_____
_____ Asthma, Emphysema (COPD) or Other Lung Disorder	_____ Pregnant	_____	_____
_____ Radiation / Chemotherapy Treatment	_____ Nervous Problems	_____	_____
_____ Cancer - Type: _____	_____ Jaw Pain / Ear Pain	_____	_____
_____ Kidney Problems / Dialysis	_____ Headaches	_____	_____
_____ Dementia / Alzheimer's Disease	_____ Drug Addiction _____	_____	_____
_____ Vertigo	_____ Diabetes or Other Endocrine Disorder	_____	_____
_____ Fever Blisters / Recurrent Cold Sores	_____ Epilepsy, Convulsions or Fainting Spells	_____	_____
_____ Thyroid Disease	_____ Dry Mouth	_____	_____
_____ Unusual Reaction to Any Drug or Local Anesthetic _____	_____ Other: _____	_____	_____
_____	_____	_____	_____

_____ Serious Illness if so, please list: _____

_____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. David R. Sullivan. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities and treatment plans in connection with all claims and procedures. It is my responsibility to inform the dental office of any changes in my status. I acknowledge that I have been provided a copy of this Dental Practice's HIPPA Notice of Privacy Practices.

Signature_____ Date_____

Medical Information Release Form

(HIPAA Release)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Signed: _____ Date: _____

Authorization to Release Dental Records

I _____ so hereby consent and

authorize _____ to share the information in my dental record, including current and previous records from other practices and practitioners, hospitals and/or clinics which are a part of my dental records to:

David R. Sullivan D.D.S.
336.288.8745
2713 Pinedale Road
Greensboro, NC 27408
drdsullivandds@gmail.com

Patient date of birth is (mm/dd/yy): _____,

_____

Patient Signature

_____

Date

Additional consent is necessary from a person authorized to give consent, other than the patient, such as a parent or guardian.

_____

Parent / Guardian Signature

_____

Date