REGISTRATION AND HEALTH HISTORY

Patient Information (please print):

Last Name _____ **First Name** _____ **Middle Initial** _____

Nickname _____ **Patient's Date of Birth** ____ / ____ / ____ ____ **Age** ☐ **Male** ☐ **Female**

***If this appointment is for your child, your name** _____

Patient's Address _____ **City** _____ **State** _____ **Zip** _____ _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____ **Cell Phone** (____) _____ - _____

Personal E-mail Address _____ **Work E-mail Address** _____

Employed by _____ **How long?** _____ **Occupation** _____

Marital Status (check one) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Spouse's Last Name _____ **First Name** _____ **Middle Initial** _____

Spouse's Date of Birth ____ /_____ /_____ **Social Security #** _____ **Or ID** _____

Home Phone (____) ____ - _____ **Work Phone** (____) ____ - _____ **Cell Phone** (____) _____ - _____

Personal E-mail Address _____ **Work E-mail Address** _____

Employed by _____ **How long?** _____ **Occupation** _____

DENTAL INSURANCE INFORMATION

Please provide us with your insurance card to copy for your file.
We are happy to assist you in filing your insurance; however, you are responsible for your account balance.

Primary Insurance Information (please print)

Subscriber's Last Name _____ **First Name** _____ **Middle Initial** _____

Patient's Relationship to Subscriber (check one) ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Subscriber's Social Security # ____ / ____ / ____ **Subscriber's Date of Birth** ____ / ____ / ____

Subscriber's Address _____ **City** _____ **State** _____ **Zip** _____

Name of Employer _____ **Group#** _____ **ID #** _____

Insurance Company & Mailing Address _____

City _____ **State** _____ **Zip** _____ **Phone** (____) _____ - _____

Secondary Insurance Information (please print)

Subscriber's Last Name _____ **First Name** _____ **Middle Initial** _____

Patient's Relationship to Subscriber (check one) ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Subscriber's Social Security # ____ / ____ / ____ **Subscriber's Date of Birth** ___ /___/___

Subscriber's Address _____ **City** _____ **State** _____ **Zip** _____

Name of Employer _____ **Group#** _____ **ID #** _____

Insurance Company & Mailing Address _____

City _____ **State** _____ **Zip** _____ **Phone** (____) _____ - _____

ACCOUNT INFORMATION

Person Financially Responsible for Account _____

Address _____ **City** _____ **State** _____ ____ **Zip** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____ **Cell Phone** (____) _____ - _____

Emergency Contact Person _ _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____ **Cell Phone** (____) _____ - _____

How did you hear about our office (referral)? ☐ **Radio** ☐ **Internet** ☐ **Family/Friend** ☐ **Yellow Pages** ☐ **Dr. Referral**

☐ **Other** _____

(OVER)

DENTAL HISTORY

1. Who was your former dentist? Name _____

   City _____ State _____ Zip _____ Phone (___) _____ - _____

2. When was your last dental treatment? ____ /_____/_____ Type of Treatment _____

3. Are you having pain or discomfort at this time? ☐ YES ☐ NO Where? _____

4. How would you describe your present dental health? ☐ Good ☐ Fair ☐ Poor

5. Have you experienced any unfavorable reaction to any previous dental treatment

   (anesthetic reaction, pain, other)? ☐ YES ☐ NO

6. Are you satisfied with your tooth appearance? ☐ YES ☐ NO

7. Are you satisfied with your tooth color? ☐ YES ☐ NO

8. Do you feel your teeth are: ☐Crowded? ☐ Poorly Aligned? ☐ Protruding?

9. Do you have fractures in your front teeth? ☐ YES ☐ NO

I0. Are you hiding your teeth while smiling? ☐ YES ☐ NO

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? ☐ YES ☐ NO

2. Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO

3. Have you taken any medicine or drugs during the past two years? ☐ YES ☐ NO

   If yes, please list _____

   _____

4. Do you take any of the following bisphosphonates such as? ☐ Fosamax ☐ Actonel ☐ Resclast

   ☐ Other _____

5. Are you aware of being allergic to any medications, latex, or substances? ☐ YES ☐ NO

   If yes, please list _____

6. Please check if you have ever used any of the following substances? ☐ Tobacco/Frequency _____

   ☐ Alcohol/Frequency _____

7. Preferred Pharmacy: _____

8. Check any of the following which you have had or have at present:

☐ Heart Murmur	☐ Anemia	☐ Arthritis
☐ Mitral Valve Prolapse	☐ Blood Transfusion	☐ Bruise Easily
☐ Rheumatic Fever	☐ Chemotherapy/Radiation	☐ Epilepsy
☐ Artificial Joints	☐ Drug Addiction	☐ Fainting
☐ Heart Problems	☐ Kidney Trouble	☐ Glaucoma
☐ High Blood Pressure	☐ Pain in Jaw Joints	☐ Headaches
☐ Emphysema	☐ Psychiatric Treatment	☐ Liver Disease
☐ Asthma	☐ Tuberculosis	☐ Seizures
☐ Diabetes	• persistent cough	☐ Sickle Cell Diseases
☐ A.I.D.S.	• bloody sputum	☐ Sinus Trouble
☐ Hepatitis A (infectious)	• anorexia	☐ Stroke
☐ Hepatitis B (serum)	• fever	☐ Venereal Disease
☐ Hepatitis C	☐ Thyroid Disease	☐ Acid Reflux
☐ H.I.V.	☐ Ulcers	

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____

Are you taking birth control pills? ☐ YES ☐ NO

9. Do you have any disease, condition or problems not listed? If yes, please list: _____

_____

Patient / Parent / Guardian Signature _____ **Date**____ / ____ / ____

Consent:
The undersigned acknowledges reading the Informed Consent form and hereby authorizes the Practice to take radio-graphs, photographs, or study models, and to use any other diagnostic aids deemed appropriate for accurate diagnosis of the patient's dental needs. I also authorize the Practice to perform any and all forms of treatment, medication and therapy that may be indicated. Further, I understand the responsibility of payment for dental services provided to my dependents and myself is due and payable at the time service is rendered. Having received and read the Practice Notice of Privacy, I authorize the use and disclosure of this information for the purposes of treatment, payment, dental care, and referral.

Patient: _____ Date:____ / ____ / ____

Parent/Responsible Party _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
Armstrong & Eshleman, P.A. is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of Armstrong & Eshleman's, P.A. Notice of Privacy Practices. Also, I acknowledge that I have read and understand the Information and Consent form on the back of this page and initialed the back page.

*Please print your name here:*_____

*Signature:*_____

Date: _____

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

HIPAA Acknowledgment of Receipt of the Notice of Privacy Practices
This form does not constitute legal *advice and covers only federal. not state, law.*