PATIENT INFORMATION

Physician's Name _____ Date of last visit: _____

Are you currently taking or have ever taken a Bone Health Medication? For example, ❍ Fosamax ❍ Boniva ❍ Actonal ❍ Other

Place a mark on the "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Respiratory disease	❍ Yes ❍ No
Acid reflux	❍ Yes ❍ No	Epilepsy	❍ Yes ❍ No	Shortness of breath	❍ Yes ❍ No
Artificial heart valves	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Sinus trouble	❍ Yes ❍ No
Artificial joints	❍ Yes ❍ No	Headaches	❍ Yes ❍ No	Skin rash	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Heart murmur	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Bleeding abnormally, with		Heart problems	❍ Yes ❍ No	Swollen feet or ankles	❍ Yes ❍ No
extractions or surgery	❍ Yes ❍ No	Hepatitis type____	❍ Yes ❍ No	Swollen neck glands	❍ Yes ❍ No
Blood disease	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Thyroid problems	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	High blood pressure	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Chemical dependency	❍ Yes ❍ No	Kidney disease	❍ Yes ❍ No	Ulcer	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Liver disease	❍ Yes ❍ No	Weight loss, unexplained	❍ Yes ❍ No
Compromised		Low blood pressure	❍ Yes ❍ No	Are you currently pregnant	❍ Yes ❍ No
immune system	❍ Yes ❍ No	Mitral valve prolapse	❍ Yes ❍ No	Expected delivery date _____	
Congenital heart lesions	❍ Yes ❍ No	Osteoporosis	❍ Yes ❍ No	Other: _____	
Cortisone treatments	❍ Yes ❍ No	Pacemaker	❍ Yes ❍ No		
Cough, persistent or bloody	❍ Yes ❍ No	Radiation treatment	❍ Yes ❍ No		

MEDICATIONS

Pharmacy name _____

Phone _____

List any medications you are currently taking

_____

_____

_____

_____

ALLERGIES

Check all that apply

❍ Aspirin
❍ Codeine
❍ Latex
❍ Local anesthetic
❍ Penicillin
❍ Sulfa
❍ Other_____

_____

_____

PATIENT AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to in form Heritage Hill Dental of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment.

_____/_____
Signature of Patient/Personal Representative Date

HERITAGE HILL DENTAL ADULT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient Name _____

Preferred Name _____

Address _____

_____

City _____ Zip_____

Phone Home _____

Cell _____

Work _____ Ext._____

Sex ❍ Male Date of Birth _____

❍ Female SS#_____

❍ Married ❍ Widowed ❍ Divorced ❍ Single ❍ Separated

Patient Employer/School _____

Occupation _____

Spouse/Partner's Name _____

Phone (cell) _____

Spouse/Partner's Employer _____

How did you hear about us? _____

EMERGENCY NUMBER

(Specify someone who does not live in household)

Name_____

Phone Home _____

Work/Cell _____

Relationship _____

DENTAL INSURANCE

Subscribers Name_____

Birthdate_____ SS#_____

Relationship to patient_____

Employer_____

Insurance Co _____

Policy_____

Group No _____

Does patient have additional insurance? ❍ Yes ❍ No

Subscribers Name_____

Birthdate_____ SS#_____

Relationship to patient_____

Employer_____

Insurance Co _____

Policy_____

Group No _____

ASSIGNMENT AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

Unless prior arrangements have been made

If this office accepts insurance, I understand that I am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Heritage Hill Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of my information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I have received a copy of this office Notice of Privacy Practices.

_____/_____

Signature of Patient/Personal Representative Date

DENTAL HISTORY

Reason for today's visit_____

_____

Date of last dental visit_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath/Bleeding gums	❍ Yes	❍ No
Dry mouth	❍ Yes	❍ No
Periodontal treatment	❍ Yes	❍ No
Implants	❍ Yes	❍ No
Tooth sensitivity	❍ Yes	❍ No
Use of any tobacco products	❍ Yes	❍ No
Orthodontic treatment	❍ Yes	❍ No
Jaw pain/tenderness	❍ Yes	❍ No
Grinding	❍ Yes	❍ No
Do you currently have a bitesplint	❍ Yes	❍ No
Do you snore	❍ Yes	❍ No

(continued on backside...)