



Patient Registration Form

8190 Barker Cypress Rd. #200
Cypress, TX 77433
Office: 832-674-4932
Fax: 832-906-6212

Patient's Name: _____ **E-mail:** _____

Home Address: _____

City: _____ **Zip:** _____ **Phone #:** _____

Employer: _____ **Business #:** _____ **Occupation:** _____

Date of Birth: _____ **Age:** _____ **SSN:** _____ **Marital Status:** _____

Spouse's Name: _____ **Phone #:** _____

Person to contact in an emergency: _____ **Relation:** _____

Address: _____ **Phone #:** _____

Reason for visit: _____

Whom may we thank for referring you? _____

Insurance Carrier: _____ **Carrier I.D.:** _____

HEALTH HISTORY

For your safety and to assist us accurately in diagnosing and treating you, please carefully review this form completely and fill out all areas, which pertain to you: **ALL INFORMATION IS KEPT CONFIDENTIAL.**

DENTAL HISTORY:

Previous Dentist: _____ City: _____

Date of last visit: _____ Date of last cleaning: _____ Date of last x-rays: _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

| | |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Mouth discomfort | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Have whitened your teeth before | <input type="checkbox"/> Loose or shifting teeth |
| <input type="checkbox"/> Grind or clench your teeth | <input type="checkbox"/> Fear of dental treatment |
| <input type="checkbox"/> Pain, clicking, or popping in jaw joints | <input type="checkbox"/> Immediate relatives that have lost all of their natural teeth |
| <input type="checkbox"/> Awake with sore jaw | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitive teeth (Hot, Cold, Sweets) |
| <input type="checkbox"/> Gum abscesses | <input type="checkbox"/> Complications with or following previous dental treatment |
| <input type="checkbox"/> Gum bleeds when brushing/flossing | <input type="checkbox"/> Cold sores or fever blisters |
| <input type="checkbox"/> Mouth odor or bad taste | <input type="checkbox"/> Other |

If you could change one thing about your smile, what would that be? _____

If there were a simple and inexpensive way to whiten your teeth, would you be interested? Yes No

Do you want to keep your teeth? _____ Yes, no matter how much trouble _____ I don't know

_____ Yes, if it's not too much trouble _____ I don't care

MEDICAL HEALTH HISTORY

1. Describe your present health: _____ Excellent _____ Good _____ Fair _____ Poor _____
2. List your current physician: _____ Type: _____
3. Date of your last physical exam: _____ Purpose: _____
4. Are you aware of any changes in your general health in the last year? Yes No
5. Have you been hospitalized for illness or surgery in the past two years? Yes No
6. Have you been under a medical doctor's care during the past two years? Yes No
7. Have you ever had excessive bleeding that requires special treatment? Yes No
8. Is there any history of diabetes in your family? Yes No
9. Are you on a special or restricted diet of any kind? Yes No
10. Do you smoke? Yes No How much? _____ How long? _____
11. Do you consume alcohol? Yes No Do you consume caffeine? Yes No
12. List all medications you are now taking (Including over the counter): _____
13. List all medications you are allergic to: _____

INDICATE WHICH OF THE FOLLOWING YOU HAD OR PRESENTLY HAVE, CIRCLE YES (Y) OR NO (N):

| | | | | | |
|-------------------------|-----|---------------------------|-----|---------------------|-----|
| A Nervous Person | N/Y | Epilepsy or Seizures | N/Y | Liver Disease | N/Y |
| AIDS | N/Y | Fainting or Dizzy Spells | N/Y | Low Blood Pressure | N/Y |
| Allergies or Hives | N/Y | Frequent Headaches | N/Y | Persistent Cough | N/Y |
| Anemia | N/Y | Frequent Thirst/Urination | N/Y | Psychiatric Care | N/Y |
| Angina | N/Y | Glaucoma | N/Y | Radiation Treatment | N/Y |
| Arthritis Rheumatism | N/Y | Hay Fever | N/Y | Rheumatic Fever | N/Y |
| Artificial Joint | N/Y | Heart Disease or Attack | N/Y | Scarlet Fever | N/Y |
| Artificial Heart Valve | N/Y | Heart Murmur | N/Y | Shortness of Breath | N/Y |
| Asthma | N/Y | Heart Pacemaker | N/Y | Sinus Trouble | N/Y |
| Blood Transfusions | N/Y | Heart Surgery | N/Y | Stroke | N/Y |
| Birth Control Pills | N/Y | Heart Trouble | N/Y | Taking hormone med | N/Y |
| Cancers or Tumors | N/Y | Hemophilia | N/Y | Thyroid disease | N/Y |
| Chemotherapy | N/Y | Hepatitis | N/Y | Tuberculosis | N/Y |
| Congenital Heart Lesion | N/Y | High Blood Pressure | N/Y | Ulcers | N/Y |
| Diabetes | N/Y | HIV Positive | N/Y | Weight Loss/Gain | N/Y |
| Drug/Alcohol Addiction | N/Y | Kidney or Bladder Trouble | N/Y | Sleep Apnea | N/Y |
| Emphysema | N/Y | Do you snore | N/Y | Are you pregnant | N/Y |

Do you have any medical conditions or diseases we should know about? N/Y

Explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medications, I will inform the doctor on or before my next appointment, without fail.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Acknowledgement Receipt: Hippa Notice of Privacy Practices

In signing this form, you agree that you have received our **Notice of Privacy Practices**. This notice among other points, explains how we plan to use and disclose your protected health information for the purpose of treatment, payment, and health care operations. This applies to the privacy practices of **O Family Dentistry** issuing this notice and entities of **O Family Dentistry** issuing this notice.

You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more details on how we may use and disclose your information. The **Notice of Privacy Practices** may change.

By signing this form, you acknowledge you have received our **Notice of Privacy Practices** and that **O Family Dentistry** and all affiliated covered entities can use and disclose your protected health information in accordance with **HIPPA**.

Signature of individual or surrogate decision maker:

Full Name:

Signature:

Date:

Relationship to resident/patient/legal authority (if applicable)

Full Name:

Relationship:

Date: