PLANO GENTLE DENTAL

New Patient Registration Form

Patient Information:

Patient's Last Name_____ First Name_____ Middle Initial_____

Preferred Name_____ Birth Date_____ Social Security #_____-_____-_____

Driver's License # _____

Home Address_____

City/State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail Address _____

Billing Address (if different): _____

City: _____ State: _____ Zip: _____

Preferred Contact Method: ( ) Home ( ) Work ( ) Cell ( ) E-mail ( ) Text

Employer: _____ Occupation: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Emergency Contact_____ Relationship to Patient_____

Emergency Contact Phone# _____

Whom may we thank for referring you? ☐ Existing Patient/Friend Name of That Person_____

☐ Internet Search ☐ Specialist Recommendation ☐ Postcard ☐ Other _____

Responsible Party (if different):

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Apt#_____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ ext.: _____ Cell Phone: _____

Sex: Male___ Female___ Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___

Birth Date: _____ Age: _____ Soc. Sec #: _____ DL#_____

Primary Insurance Info:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

Employer_____ Ins. Company_____

Ins. Mailing Address: _____

City, State, Zip: _____Phone: _____

ID#_____ Group#_____

Secondary Insurance Info:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

Employer_____ Ins. Company_____

Ins. Mailing Address: _____

City, State, Zip: _____Phone: _____

ID#_____ Group#_____

PLANO GENTLE DENTAL
Medical History

PATIENT NAME: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a Physician's care now? ○ Yes ○ No If yes, please explain: _____
Physician's name _____ Physician's number _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other _____
medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No If yes, please explain: _____

Do you smoke, chew tobacco or use e-cigarettes? ○ Yes ○ No If yes, please explain: _____

Do you use controlled substances? ○ Yes ○ No If yes, please explain: _____

Women: Are you (a.)Pregnant/Trying to get pregnant? ○ Yes ○ No If yes, anticipated due date _____
(b.)Taking oral contraceptives? ○ Yes ○ No (c.)Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ None ☐ Other If yes, please explain: _____

Do you have, or have you had any of the following?

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Heart Surgery	☐ Radiation Treatments
☐ ADHD	☐ Cortisone Medicine	☐ Hemophilia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Congenital Heart Disease	☐ Hepatitis Type: ___	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug/alcohol Addiction	☐ Hypoglycemia	☐ Renal Dialysis
☐ Anemia	☐ Diabetes	☐ Hearing difficulties	☐ Scarlet Fever
☐ Angina /Chest Pain	☐ Depression	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ High Cholesterol	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Emphysema	☐ Hives or Rash	☐ Sinus Problems
☐ Artificial Joint	☐ Epilepsy or Seizures	☐ Jaundice	☐ Spina Bifida
Type and Year: _____	☐ Frequent Cough	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Liver Disease	☐ Stroke Year: ___
☐ Blood Disease	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Glaucoma	☐ Lung Disease	☐ Stomach Ulcers/Colitis
☐ Breathing Problem	☐ Herpes Type: ___	☐ Leukemia	☐ Tonsillitis
☐ Bruise Easily	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Heart Attack/Failure Year: ___	☐ Osteoporosis	☐ Tumors or Growths
Type: _____	☐ Heart Murmur	☐ Parkinson's Disease	☐ Thyroid/Parathyroid Disease
☐ Chemotherapy	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Venereal Disease
☐ Convulsions	☐ Heart Trouble/Disease	☐ Panic Attack/Anxiety	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____
Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN_____DATE_____

PATIENT NAME: _____ Birth Date: _____

Dental History

What is the reason for your visit today? _____

Date of Last Cleaning _____ Date of Last Full Mouth Series of X-rays or PAN _____

Previous Dentist Name and Location _____

Now or in the past, have you ever had:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pain/Discomfort to chewing
- ☐ Bad Breath
- ☐ Bleeding or Swollen gums
- ☐ Food catching between Teeth
- ☐ Dry Mouth
- ☐ Broken/Worn teeth
- ☐ Gum Surgery/treatment
- ☐ TMJ Discomfort
- ☐ Jaw clicking/popping
- ☐ Difficulty opening and closing
- ☐ Difficulty chewing on either side
- ☐ Clench/grind teeth
- ☐ Canker sores/ulcers
- ☐ Cold sores/fever blisters
- ☐ Snoring
- ☐ Sleep Study performed
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Tension Headaches
- ☐ Family History of Oral Cancer
- ☐ Habits-(Nail Biting, Chewing on ice)

Now or in the past have you used: ☐ Whitening products ☐ Prescription Fluorides ☐ Nightguard ☐ Retainer

☐ CPAP If yes, please explain, _____

How often do you have dental check ups? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What other dental aids do you use? (rinses, waterpik, electric toothbrush, etc.) _____

_____

Do you like the appearance of your smile? ○ Yes ○ No

What would you like to change about your smile? ☐ Color ☐ Chipped teeth ☐ Crowding ☐ Missing teeth ☐ Bite ☐ Spaces ☐ Whiter Teeth ☐ Smile Makeover

Do you consider yourself a nervous dental patient? ○ Yes ○ No

Have you ever had an unpleasant dental experience? ○ Yes ○ No

Have you ever had problems with dental anesthesia or getting numb? ○ Yes ○ No

Is there anything else about having dental treatment that you would like us to know? ○ Yes ○ No

If yes, please describe:

_____

_____

- I authorize the Doctor to take x- rays, study models, photographs, or any other diagnostic procedures deemed appropriate by the Doctor to make thorough diagnosis of my (or the patient's) dental needs.
- I authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated.
- I authorize the release of any information concerning my (or the patient's) healthcare, advice, and treatment to another healthcare professional.

Patient (Parent/Legal Guardian) Signature:_____ Date _____

Dentist Signature:_____ Date _____

PLANO GENTLE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

The increasing demand for access to medical information by providers and others, such as insurance companies, has led to increasing concern about patient privacy and confidentiality, leading to the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This act requires providers, and others who maintain health information, to implement security measures to guard the integrity and confidentiality of patient information.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Authorization of PHI Disclosure:

The information described above may be disclosed to the following recipients:

Name of Person #1:_____ Relationship to You: _____

Name of Person #2:_____ Relationship to You: _____

Revocation of PHI Disclosure:

You may revoke this authorization by giving us a written notice of your revocation. You may not revoke this authorization during an insurance contestability period or with respect to disclosures that PLANO GENTLE DENTAL may have already made in reliance on this authorization. If you revoke this authorization, PLANO GENTLE DENTAL will no longer use or disclose your medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. If PLANO GENTLE DENTAL discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

By signing below, I am acknowledging that I have received a copy of PLANO GENTLE DENTAL's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this consent and your Notice of Privacy Practices. I am also giving PLANO GENTLE DENTAL consent for use and disclosure of my protected health information to the person(s) listed above, as well as to carry out treatment, payment activities and health care operations.

Patient Name:_____

Patient Representative:_____

If signed by Patient Representative, state authority to act on behalf of patient:

Signature: _____ Date:_____