Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	❑	❑	❑
Physician Name:			
Phone: *include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, what condition was treated?			
Date of last physical exam:			
Do you wear contact lenses?	❑	❑	❑
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	❑	❑	❑
Date Treatment Began:			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑	❑
If yes, what was the illness or problem?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If so, please list all, including vitamins, natural or herbal preparations and/ or diet supplements:			
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much alcohol did you drink in the last 24 hours?			
If yes, how much do you typically drink in a week?			
WOMEN ONLY Are you:			
Pregnant?	❑	❑	❑
Number of weeks:			
Taking birth control pills or hormone replacement?	❑	❑	❑
Nursing?	❑	❑	❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ❑ ❑ ❑
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbituates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Metals	❑	❑	❑
Latex (rubber)	❑	❑	❑
Iodine	❑	❑	❑
Hay fever / seasonal	❑	❑	❑
Animals	❑	❑	❑
Food	❑	❑	❑
Other	❑	❑	❑

	Yes	No	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart valves	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart defects	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Yes	No	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
If yes, date:			
Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/Chemotherapy/ Radiation treatment	❑	❑	❑

	Yes	No	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/Persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑

	Yes	No	DK
Neurological disorders	❑	❑	❑
If yes, specify:			
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
If yes, specify:			
Recurrent infections	❑	❑	❑
Type of infection:			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches/ Migraines	❑	❑	❑
Severe of rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑ ❑
Name of physician or dentist making recommendation: _____ Phone: ( ) _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ ❑ ❑
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

CJ Holland, DDS

General & Family Dentistry

402 South Main
Winnsboro, Texas 75494

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment that you please provide us with at least 24 hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

* Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice received this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Assignment of Benefits / Consent for Treatment

I hereby voluntarily consent to treatment at this office and authorize such examinations and/or treatments, as ordered by the attending dentist. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by my insurance. I authorize this office to release all information necessary to secure treatment and payment of services.

Patient/Guardian Signature: _____ Date: _____

Office or Other Witness Signature: _____ Date: _____

I have been provided the opportunity to read, or it has been read to me, the Policies and Procedures, and I understand the Policies and Procedures at the office of CJ Holland, DDS.

Patient/Guardian Signature: _____ Date: _____

Office or Other Witness Signature: _____ Date: _____

CJ Holland, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
PATIENT OR GUARDIAN GIVING CONSENT (PLEASE REAL THE FOLLOWING STATEMENT CAREFULLY).

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 healthcare 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 your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices we 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. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at anytime by contacting our office at (903) 342-3509.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone _____
- □ OK to leave message with detailed information
- □ Leave message with call back number only

□ Written Communication
- □ OK to mail to my home address
- □ OK to mail to my work/office address

□ Work Telephone _____
- □ OK to leave message with detailed information
- □ Leave message with call back number only

- □ OK to fax to number _____
- □ Other (Fax/Cell, etc.) _____

**As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls or texts at this number. # _____ (Please initial) _____

I allow you to give my clinical information to or answer questions from (check all that apply):
□ Spouse □ Parent □ Child □ None □ Other (specify): _____

I allow you to give or discuss my financial information to or answer questions from (check all that apply):
□ Spouse □ Parent □ Child □ None □ Other (specify): _____

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____