Patient Registration

Name: _____

Address: _____

City, State, Zip: _____

single married widowed divorced separated minor

Social Security Number _____ Birth Date _____

Spouse or Parent's Name _____

Where do you prefer to receive calls? Home Business Mobile

Home Phone (___) _____ Mobile Phone (___) _____

Business Phone (___) _____ Ext.#_____ Email _____

Who May We Thank For Referring You _____

Person **to Contact in Case of Emergency** _____

Relationship to Patient _____ Phone Number (_____) _____

Financial Responsibility for this Account

Name_____ Birth Date _____

Occupation _____ Social Security Number _____

Business or Employer Name _____

Business or Employer Address _____

I agree to be responsible for payment of all services rendered on my behalf and my family members.

X_____ _____

Signature Today's Date

{Signature of parent if patient is a minor}

Medical History

Some of these questions may not relate to your medical condition; in that event please indicate by writing "N/A" (not applicable) in the space provided. **All questions must be answered**. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. *ALL INFORMATION YOU SUPPLY ON THIS FORM, THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR WRITTEN PERMISSION.*

1. Name, address & telephone number of your physician_____

_____

2. Date of last complete physical exam_____
3. Do you suffer from any disability?____If yes, describe_____
4. Have you ever, or do you now, take illegal drugs?_____If yes, what drugs, and when taken?_____

_____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS or are you HIV-positive? _____ If yes, describe and provide current status_____

_____

6. Do you now have, or have you ever had, a venereal disease? ____ If yes, describe. _____
7. Have you ever had, or do you now, have hepatitis? ____ If yes, describe._____
8. For females: Are you pregnant? If yes, when are you due? _____
9. For females: Are you taking birth control pills? ☐Yes ☐No

Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.

10. Are you taking any drugs or health related medications? _____ If yes, list and describe amounts and purpose. _____

_____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication, latex or metal? _____ If yes, describe._____

_____

12. Have you lost weight recently? ___ If yes, describe. _____

Have You Ever Had or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?_____
14. Heart trouble, heart attack, irregular beats, angina, heart surgery, stent, valve implants or a pacemaker?_____
15. Stomach or intestinal disease?_____
16. Abnormal blood pressure, excessive bleeding or anemia? _____
17. Breathing problems, asthma, tuberculosis or hay fever? _____
18. Cancer, X-ray treatments or chemotherapy? _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis, inflammatory disease or rheumatism _____
24. Have you ever had a major operation?____ If yes, describe. _____
25. Have you ever had a serious injury to your head or neck, or had an artificial prosthesis or joint replacement? _____
26. Are you on a special diet?____If yes, for what reason and describe. _____
27. Do you smoke, chew tobacco or pinch snuff? ____If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist or counselor? __ If yes, describe. _____
29. Are there any other problems about your health of which you are aware? _____

I certify this health history information is accurate to the best of my knowledge.

X _____ _____

Signature Today's Date

MEDICAL HISTORY

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

1. I acknowledge that I have received or reviewed a copy of this office's "Notice of Privacy Practices".
2. I authorize Marcotte Dental Associates to take photographs, videos and x-rays of my face, jaw and the hard and soft tissues of my mouth for **diagnosis and treatment** purposes. I understand these photographs, videos and x-rays are a part of my protected health information.
3. By signing this form, I consent to Marcotte Dental Associates' use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This authorization will stay in effect for 10 years from the date signed.

X _____ _____

Signature Today's Date

Authorization for Disclosure of Patient Information

I authorize the release of information including treatment / diagnosis related information, appointment details and / or records; examination rendered to me and financial particulars. This information may be released to:

_____

_____

_____

This Release of Information will remain in effect for 10 years or until terminated by me in writing.

Signed: _____ Date _____

Witness:_____ Date _____

Authorization for Use or Disclosure of Patient Photographic and Video

****You May Refuse to Sign This Acknowledgement****

1. I authorize the use and disclosure of my smile and face photographic and video images and/or testimonial for **marketing** purposes by Marcotte Dental Associates, P.C.. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.
2. The purpose of these smile and face photographic and video images are for social media and marketing for Marcotte Dental Associates, P.C. and I may revoke this authorization in writing at any time. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 10 years from the day signed.

X _____ _____

Signature Today's Date