

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
{Signature of parent if patient is a minor}

Today's Date

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.

X _____
Signature

Today's Date

Authorization for Use or Disclosure of Patient Photographic and Video Images

****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 99 years from the day signed.

X _____
Signature

Today's Date