PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F

I prefer to be called: _____ Birthday: ___/___/___ Age: _____ Single Married Divorced

Social Security #: _____ Drivers License#: _____ Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Ext.: _____ Cell #: _____

Whom may we Thank for referring you? _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If patient is a student-Name of school: _____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #.: ( ) _____

Address: _____ Work Phone #.: ( ) _____
Street City State Zip

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #.: ( ) _____

Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

Spouse/Parent Information

Name: _____ Birthday: ___/___/___ Social Security #.: _____

Employer: _____ Work Phone #: ( ) _____ Ext.: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insureds' Name: _____ SS#: _____ Insureds' Birthday.: ___/___/___ Relation: _____

Insureds' Employer: _____ Employer Address: _____
Street City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ SS#: _____ Insured's Birthday.: ___/___/___ Relation: _____

Insured's Employer: _____ Employer Address: _____
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

Signature - Patient or Responsible Party _____ Date _____

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Name of Physician_____ Phone: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: _____

Are you taking any prescription/over the counter drug(s)? Y N Please explain: _____

Please list each one: _____

Have you ever had any serious illness or operation? Y N Please explain:_____

DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION. Please explain: _____

FOR WOMEN

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart Attack/Stroke	Y	N	High or Low Blood Pressure	Y	N	Ulcers
Y	N	Cancer/Chemotherapy	Y	N	Fever Blister	Y	N	Congenital Heart Defect
Y	N	Heart Murmur	Y	N	Severe/Frequent Headaches	Y	N	Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Cardiac Pacemaker	Y	N	Asthma
Y	N	Heart Surgery/Pacemaker	Y	N	Psychiatric Problems	Y	N	Difficulty Breathing
Y	N	Shingles	Y	N	Epilepsy/Seizures/Fainting	Y	N	Hospitalized for any reason
Y	N	Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Kidney Problems	Y	N	Drug/Alcohol Abuse	Y	N	Blood Transfusion
Y	N	Artificial Bones/Joints	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding	Y	N	HIV+/AIDS
Y	N	Sinus Problems	Y	N	Glaucoma	Y	N	Anemia
Y	N	Tuberculosis (TB)	Y	N	Colitis	Y	N	Arthritis

Please list any medical condition(s) that you have ever had: _____

Are you allergic to any of the following drugs or materials?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Codeine	Y	N	Antibiotics
Y	N	Sulfa Drugs	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to:_____

MEDICAL HISTORY

Previous Dentist_____ Phone: _____

Dental Complaint at this moment? _____

Have you ever had any unfavorable reaction from a local anesthetic? _____

Have you ever had any serious trouble associated with any previous dental treatment? _____

Explain: _____

How long since last dental X-Rays of your entire mouth? _____ How long since last dental treatment? _____

Do you have or do you use any of the following?

Y	N	Bleeding gums	Y	N	Complications from extractions	Y	N	Water jet device
Y	N	Food impaction	Y	N	Periodontal (gums) treatment	Y	N	Fluoride supplements
Y	N	Clenching or grinding	Y	N	Orthodontic treatment	Y	N	Fluoride treatments
Y	N	Bad breath	Y	N	Cigarettes, pipe or cigar smoking			
Y	N	Unpleasant taste	Y	N	Dental floss			

CONSENT FOR TREATMENT: I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date_____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

MEDICATION WARNING

Patients who have taken bisphosphonate medications to strengthen bones, now or in the past, should inform their dentist immediately. If you have taken any of the following medications, please indicate below:

- ☐ Fosamax
- ☐ Aredia
- ☐ Actonel
- ☐ Boniva
- ☐ Zometa
- ☐ Didronel
- ☐ Skelid
- ☐ I have never taken any of these medications.

_____

(Signature of patient or guardian if a minor) (Date)

ACKNOWLEDGEMENT FORM FOR (HIPAA) NOTICE OF PRIVACY PRACTICES

As of April 2003, the Health Information Portability and Accountability Act (HIPAA) took effect and we want you to know that we take this seriously. Our office is HIPAA compliant when handling your private health information. We may at times be required to electronically transmit your information related to Insurance claims or in association with treatment in conjunction with another healthcare provider or interested party. We will not, without your consent share any private health information with others. We may use or disclose health information about you when contacting you to remind you of a dental appointment. We may contact you by using a letter, voicemail, text or email. To see the complete HIPAA compliance statement, see our front desk.

_____ _____

(Signature of patient or guardian if a minor) (Date)

OUR OFFICE POLICY FOR CANCELLAITON OF APPOINTMENTS

Please give our office a 48 hour work day notice if you need to cancel or change your appointment for any reason. As we are not in on Fridays, if you need to change your Monday appointment, please call by Thursday 8:00 a.m. Failure to give a notice will result in the charge of a cancellation fee for time reserved of $35 with the hygienist and $50 per hour scheduled with Dr. Stockwell.

_____ _____

(Signature of patient or guardian if a minor) (Date)

Smile Assessment Form

Stockwell Family Dentistry

1. I am concerned about the appearance of my teeth or my smile.	YES	NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3. I am concerned about the position or angle of one or more of my teeth.	YES	NO
4. In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
5. I have previous dental treatment that is no longer satisfactory to me.	YES	NO
6. I am missing one or more of my teeth.	YES	NO
7. I am interested in learning more about esthetic dentistry.	YES	NO

Please use the space below to indicate any other problems, concerns or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you!

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION