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DENTALCARE ASSOCIATES
COSMETIC, IMPLANT, AND FAMILY DENTISTRY

Patient Registration • Medical History
Treatment Consent • Privacy Practices Acknowledgement

Please complete both sides. Duplicate information may be left blank. If help is needed completing this form, please ask reception for assistance.

Person Responsible For The Account

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐		Address:	
Last Name:		Apt. No.:	
First Name:	MI:	City:	
Social Security:	Sex: M ☐ F ☐	State:	Zip:
Date of Birth:	Age:	☎ Home Phone:	
E-Mail:		☎ Cell Phone:	

Employer and Insurance Information

Employer:		Dental Ins. Co.:	
Address:		Address:	
City:		City:	
State:	Zip:	State:	Zip:
☎ Business Phone:	Ext:	Group No.:	ID No.:

Spouse Information

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐		Address:	
Last Name:		Apt. No.:	
First Name:	MI:	City:	
Social Security:	Sex: M ☐ F ☐	State:	Zip:
Date of Birth:	Age:	☎ Home Phone:	
E-Mail:		☎ Cell Phone:	

Spouse Employer and Insurance Information

Employer:		Dental Ins. Co.:	
Address:		Address:	
City:		City:	
State:	Zip:	State:	Zip:
☎ Business Phone:	Ext:	Group No.:	ID No.:

Patient Information

Last Name:		Purpose of Visit:	
First Name:	MI:		
Address:			
City:		Referred By:	
State:	Zip:		
☎ Contact Phone:	Sex: M ☐ F ☐	Please complete the Medical History and sign the Treatment Consent and Privacy Acknowledgement on other side.	
Date of Birth:	Age:		

Patient Medical History

Please complete the following medical history to the best of your knowledge.
If you have any medical conditions or you are taking any medications, please describe under remarks below.

1. *Are you in good health* ..... *Yes* ☐ *No* ☐
2. *Have there been any changes in your health within the past year*..... *Yes* ☐ *No* ☐
3. *Have you had any serious illness or operation in the past five years*..... *Yes* ☐ *No* ☐
4. *Are you taking any medications, including non-prescription or recreational drugs*..... *Yes* ☐ *No* ☐
5. *Have you had adverse reactions or unpleasant experiences with previous dental treatment*..... *Yes* ☐ *No* ☐
6. *Please check if you have or have had any of the following:*

☐ *Heart Disease*	☐ *High Blood Pressure*	☐ *Abnormal Heart Condition*
☐ *Blood Disorders*	☐ *Rheumatic Heart Disease*	☐ *Diabetes*
☐ *Hepatitis Type ___*	☐ *HIV or Immune Deficiency*	☐ *Sexually Transmitted Disease*
☐ *Seasonal Allergies*	☐ *Allergies to Medications*	☐ *Allergies to Anesthetics*
☐ *Allergies to Latex*	☐ *Stomach or GI Disorders*	☐ *Arthritis or Back Pain*
☐ *Seizures*	☐ *Radiation Therapy*	☐ *Tuberculosis*
☐ *Aspirin Therapy*	☐ *Women: Are You Pregnant?*	☐ *Other (Describe below)*

Remarks:

Name of Physician:	*Name of Previous Dentist:*
Address:	*Address:*
City, State, Zip:	*City, State, Zip:*
☎ *Physician Phone:*	☎ *Dentist Phone:*
Date of Last Medical Treatment:	*Date of Last Dental Treatment:*

Treatment Consent and Notice of Privacy Practices Acknowledgement

Treatment Consent:

Initial Below

I certify that the information provided to Dentalcare Associates PA is accurate to the best of my knowledge. By affixing my initials, I authorize Dentalcare Associates PA to perform the necessary diagnostic procedures and provide the necessary dental care for the above named patient for treatment agreed upon, either written or verbally presented. ☐

By affixing my initials, I agree to follow the financial policies of Dentalcare Associates PA, including 1.5% monthly interest for accounts overdue more than 60 days. I understand that I am entitled to a copy of the financial policies and a written estimate prior to commencement of treatment. I also understand that I am fully responsible for all fees incurred regardless of insurance coverage. ☐

Notice of Privacy Practices:

I have received and read this practice's Notice of Privacy Practices. By affixing my initials, I give consent to Dentalcare Associates PA to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations. I have the right to revoke this consent at any time by written notice. I understand that if consent is not provided, Dentalcare Associates PA cannot release any information for billing, processing insurance claims, sending appointment reminders, or other purposes according to the law. I also understand that I will be responsible for payment in full at time of treatment for not providing consent. ☐

✍ *Signature of Responsible Party:*	*Date:*