**Ramani Dentistry**

**Registration and Dental History**

PATIENT NAME: DATE:

ADDRESS: PATIENT’S BIRTHDATE:

CITY, STATE, ZIP SPOUSE’S BIRTHDATE:

PHONE: HOME WORK IF UNDER 21 YEARS OF AGE:

CELL FATHER’S BIRTHDATE:

PLEASE PUT A NUMBER 1-3 IN THE ORDER IN WHICH IT IS BEST TO REACH YOU. MOTHER’S BIRTHDATE:

EMAIL SOCIAL SECURITY #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE FOR THIS PATIENT IS PROVIDED BY MYSELF SPOUSE BOTH PARENT

**INSURANCE HISTORY**

PRIMARY: SECONDARY:

SUBSCRIBER NAME: SUBSCRIBER NAME:

PLACE OF EMPLOYMENT: PLACE OF EMPLOYMENT:

DENTAL INSURANCE CO.: DENTAL INSURANCE CO:

INSURANCE CO. PHONE #: INSURANCE CO. PHONE #:

GROUP/POLICY #: GROUP/POLICY #:

CONTRACT ID #: SS#: CONTRACT ID #: SS#

**OTHER INFORMATION**

**IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? SAME HOUSEHOLD?**

**PHONE # RELATION TO PATIENT?**

**HOW DID YOU HEAR ABOUT OUR OFFICE?**

WHY DID YOU CHANGE DENTISTS?

WHO WILL PAY THIS ACCOUNT?

**DENTAL HISTORY**

ARE YOU HAVING DISCOMFORT AT THIS TIME? WHERE?

DATE OF LAST DENTAL VISIT: FOR WHAT SERVICE?

HOW FREQUENT WERE VISITS BEFORE THEN?

HOW OFTEN IS TOOTHBRUSHING DONE? WHEN?

DO YOU USE DENTAL FLOSS? HOW OFTEN?

WOULD YOU LIKE YOUR TEETH TO BE WHITER?

WOULD YOU LIKE YOUR TEETH TO BE STRAIGHTER?

DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR TEETH?

DO YOU HAVE ANY FEAR OF HAVING DENTISTRY DONE? WHY?

DO YOU HAVE ANY HISTORY OF ORTHODONTICS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU PARTICIPATE IN SPORTS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT QUESTIONS OR CONCERNS DO YOU WANT THE DOCTOR TO ADDRESS?

**AUTHORIZATION TO PAY BENEFITS TO DENTIST:**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE INSURANCE BENEFIT OTHERWISE PAYABLE TO ME FOR THIS SERVICE.

**PATIENT SIGNATURE:**  DATE:

**Ramani Dentistry**

**Registration and Dental History**

PHYSICIAN’S NAME: ADDRESS: \_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO ARE YOU UNDER CARE OF PHYSICIAN NOW? FOR WHAT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO ARE YOU TAKING ANY MEDICATIONS OR DRUGS?

 PLEASE LIST, INCLUDING VITAMINS AND BIRTH CONTROL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO IS THERE ANY EXCESSIVE BLEEDING WHEN CUT?

YES NO HAVE YOU EVER BEEN HOSPITALIZED? IF SO FOR WHAT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO HAVE YOU EVER HAD SURGERY? IF SO FOR WHAT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO IS THERE ANY ALLERGY TO PENICILLIN?

YES NO IS THERE ANY ALLERGY TO LOCAL ANESTHETIC?

YES NO ARE THERE ANY OTHER ALLERGIES: DRUGS, FOOD, POLLEN, ETC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO ARE THERE ANY PHYSICAL CONSIDERATION WE SHOULD KNOW ABOUT (BACK

PROBLEMS, ETC.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO DO YOU HAVE ANY ALLERGY TO LATEX?

YES NO ARE YOU A SMOKER OR DO YOU CHEW TOBACCO?

YES NO ARE YOU PREGNANT?

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

 ABNORMAL HEART CONDITION MALIGNANCIES

IF SO, PLEASE LIST YOUR CARDIOLOGIST’S NAME & PHONE NUMBER (CANCER) MONONUCLEOSIS

 ANEMIA NERVOUS PROBLEMS

 ARTHRITIS ORGAN TRANSPLANT

 ASTHMA PSYCHIATRIC CARE

 CIRCULATORY PROBLEMS RADIATION TREATMENT

 CONVULSIONS RHEUMATIC FEVER

 DIABETES SINUS PROBLEMS

 EPILEPSY STROKE

 FAINTING THYROID

 HEPATITIS T.M.J.

 HERPES TUBERCULOSIS

 HIGH BLOOD PRESSURE ULCER

 LOW BLOOD PRESSURE VENEREAL DISEASE

 A.I.D.S H.I.V. POSITIVE

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE:** DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ramani Dentistry**

**PATIENT CONSENT TO RECEIVE MAIL, EMAIL AND/OR TELEPHONE MESSAGES**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(PLEASE PRINT)* LAST NAME FIRST NAME M.I.

I AGREE THAT THE PRACTICE MAY COMMUNICATE WITH ME ELECTRONICALLY AT THE FOLLOWING EMAIL ADDRESS AND PHONE NUMBER:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(PLESE PRINT)* EMAIL ADDRESS

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(PLEASE PRINT)* CELL PHONE NUMBER FOR TEXT

**DO WE HAVE YOUR PERMISSION TO:**

SEND A RECALL APPOINTMENT REMINDER TO YOUR HOME? \_\_\_\_YES or \_\_\_\_NO

LEAVE AN APPOINTMENT, BILLING OR DENTAL INFORMATION

ON YOUR ANSWERING MACHINE/VOICEMAIL/EMAIL? \_\_\_\_YES or \_\_\_\_NO

I GIVE PERMISSION TO SHARE APPOINTMENT, BILLING OR DENTAL INFORMATION WITH THE PERSON NAMED BELOW:

 NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT/PARENT OR LEGAL GUARDIAN DATE

IF SIGNED BY OTHER THAN THE PATIENT, SPECIFY RELATIONSHIP TO PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENTOF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I am aware that a copy of the office privacy act is available upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PATIENT/PARENT OR LEGAL GUARDIAN** DATE

IF SIGNED BY OTHER THAN PATIENT, SPECIFY RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPAA CONSENT

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

\_\_\_\_ PATIENT/PARENT OR LEGAL GUARDIAN REFUSED TO SIGN FORM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 SIGNATURE OF OFFICE MANAGER DATE