PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Date: _____ Email _____

Patient _____

(Last Name) (First Name) (Initial) (Preferred Name)

☐ Male Married Single Divorced Widowed
☐ Female

Age _____ Birthday _____/_____/_____ Social Security# _____-_____-_____

Street Address _____ City _____ State _____ Zip _____

Telephone (Cell) _____ (Work) _____ (Home) _____

Who may we thank for referring you? _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's SS# _____	Policy Holder's SS# _____
Policy Holder's DOB _____	Policy Holder's DOB: _____
Subscriber ID: _____	Subscriber ID: _____
Relationship to Subscriber: _____	Relationship to Subscriber: _____
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone: _____	Insurance Phone: _____

**Please present your insurance card to be photocopied for our records

RESPONSIBLE PARTY *(If patient is under 18)*

Last Name _____ First _____ Initial_____

Address (If different) _____ State _____ Zip _____

Telephone (Cell) _____ (Work) _____ (Home) _____

Relationship to patient _____ _____

EMERGENCY CONTACT

Last Name _____ First _____ Initial _____

Telephone (Cell) _____ (Work) _____ (Home) _____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

Signature _____ Date _____

(Responsible Party, if under 18)

DATE:_____

MEDICAL HISTORY

Patient NAME (Last)_____ (First)_____

Date of Birth: _____/_____/_____

Physician's Name_____ last visit date _____/_____/_____

Physician's Phone _____ Name of practice_____

Have you had any serious illness or operations? Yes / No

If yes, please describe_____

Have you ever had a blood transfusion? Yes / No If yes, give approximate dates _____/_____/_____

(Women)Do you suspect you are pregnant? Yes / No If yes, what is the due date? _____/_____/_____

Are you nursing? Yes / No Are you taking birth control pills? Yes / No

Please check if you have/had:

____Allergies, Hay Fever, Sinusitis	____Anxiety: what type:_____	____Arthritis, Rhematism
____Artificial Heart Valves	____Artificial Joints	____Back Problems
____Blood disease,clotting disorder	____Blood Thinners	____Cancer/Chemo/Radation
____Chemical dependency	____Circulatory problems	____Diabetes: type:_____
____Epilepsy	____Headaches	____Heart Murmur
____Hemophilia	____Hepatitis: type:_____	____High Blood Pressure
____Jaundice	____Liver disease	____Low Blood Pressure
____Mitral Valve Prolapse	____Respiratory disease	____Rheumatic Fever
____Sinus problems	____Stroke: year:_____	____Thyroid disease
____Ulcer	____Venereal disease	____Weight loss
____AIDS/HIV		

*Are you ALLERGIC to LATEX? YES / NO

*Are you ALLERGIC to Penicillin, Aspirin, or other drugs? _____

*List any medications that you are taking: _____

_____

*Have you had any unpleasant experience at the dental office? If so what: _____

_____

Is there anything you would change about your smile?_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

FULSHEAR DENTAL

Acknowledgement of HIPAA Notice of Privacy Practices

Aekta Fifadara, DMD

7619 Tiki Lane, Suite A

FM 1093 FULSHEAR, TX 77441

Acknowledgement

I understand that Fulshear Dental *HIPAA Notice of Private Practices* may change periodically and upon request I may receive a copy of Fulshear Dental revised *HIPAA Notice of Private Practices*.

I understand that it is my right to refuse to sign this Acknowledgement should I do choose, and that Fulshear Dental will not refuse treatment to me if I refuse to sign this Acknowledgement.

I understand that I may contact the Secretary of the U.S Department of Health and Human Services should I have concerns regarding Fulshear Dental privacy policies and procedures. For information how to contact the U.S Department of Health and Human Services, please ask a staff member above for assistance.

_____ _____

(Patient Signature) (Date)

I, _____, understand that by signing this Consent form, I am giving my consent to *Fulshear Dental* to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following **family member:**

I consent that Fulshear Dental may use photographs or videos of me on social media tools which includes but is not limited to their Facebook page and Instagram page. I understand that these images and / or videos will not be used for any commercial purposes.

_____ Initial if you DECLINE photo consent

Name: _____ Relationship: _____