Registration/Medical History/HIPAA

Patient's Name_____ Date of Birth_____ SSN_____

Address_____
Street City State Zip

Name you wish to be called_____

Employer_____

Phone (H)_____ (W)_____ (C)_____

E-mail_____

General Dentist_____

In Case of Emergency_____ Phone_____

Spouse's Name_____ DOB_____ SSN_____

Spouse's Phone_____

If Different from Patient, Please Fill Out Information Below:

Person responsible for Account_____ DOB_____ SSN_____

Relationship to Patient_____ Phone(H)_____ (W)_____ (C)_____

Complete this section if Covered by **Dental Insurance**: Name of Person Insured_____

Name of Insurance Company:_____

Soc. Sec. No:_____ Employer_____ DOB of Insured_____

Address_____ Phone_____ Group or ID_____

For those patients with dental insurance as a method of payment, their co-payment is required at the start of treatment. For patients needing only a consultation, we request that you pay us in full at the time of service and have your insurance company assign payment to you.

Please check YES or NO to answer the following questions and provide explanation where needed:

1. Yes___No___ Have you been treated by a doctor or been in the hospital in the last 2 years? If yes, why?

_____

2. Yes___No___ Are you taking any medications at this time? If yes, please list the medications:

_____

3. Yes___No___ Have you ever had an allergic, or unusual reaction to any medication? If yes, please list medications:

_____

4. Have you had, or do you presently have any of the following conditions? **Please check Yes or No.**

YES___NO___	Heart attack, disease, surgery	YES___NO___	Diabetes
YES___NO___	Angina or chest pain	YES___NO___	Chemotherapy or Radiation
YES___NO___	Heart Murmur	YES___NO___	AIDS or HIV Positive
YES___NO___	Rheumatic Fever	YES___NO___	Hepatitis, Jaundice, Liver Disease
YES___NO___	Mitral Valve Prolapse	YES___NO___	Hemophilia or Excessive Bleeding
YES___NO___	Artificial Heart Valve	YES___NO___	Sexually Transmitted Diseases
YES___NO___	Heart Pacemaker	YES___NO___	Asthma
YES___NO___	Stroke	YES___NO___	Stomach or Intestinal Ulcers
YES___NO___	Kidney Disease	YES___NO___	Hay Fever or Sinus Trouble
YES___NO___	Epilepsy	YES___NO___	Thyroid Disease
YES___NO___	Lung Disease Including TB	YES___NO___	Drug or Alcohol Problem
YES___NO___	High Blood Pressure	YES___NO___	Arthritis

5. **Women Only**: Are you pregnant? _____How many months?_____Breast Feeding?_____Taking Birth Control?_____

6. Is there any other aspect of your medical history that has not been covered in the above questions?

_____

Informed Consent: To the best of my knowledge, all of the preceding answers are true and correct. I give Dr. Piepenbring permission to perform the necessary evaluation and treatment as indicated. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

Acknowledgement of Notice of Privacy Practices: I, _____, have read and/or received a copy of this office's notice of Private Practices.

Signed_____ Date_____