Los Gatos Family Dentistry

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PATIENT REGISTATION FORM

DATE: _____ NAME: _____
Last First Middle Initial

ADDRESS: _____
Street Unit City State Zip

HOME PHONE #: _____ CELL PHONE #: _____ EMAIL: _____

SOCIAL SECURITY #_____ AGE: _____ BIRTHDATE: _____SEX:_____

OCCUPATION: _____EMPLOYER NAME: _____ WORK PHONE #:_____

In case of emergency, contact: _____
Last First Phone # Relationship

Check Appropriate Box: ☑ Single ☑ Married ☑ Domestic Partnership ☑ Widowed ☑ Separated ☑ Divorced

If the patient is a student please provide the requested information below to be submitted with dental insurance claims.

_____
School/College City State

How did you hear about our Practice? _____

FINANCIAL RESPONSIBLIITY

I understand that Los Gatos Family Dentistry will bill my insurance carrier on my behalf; however, I am financially responsible for all charges incurred whether or not they are paid by my insurance or other third parties, and that estimates provided to me are not a guarantee of insurance coverage or payment. My signature below may be used on all insurance submissions and credit card payments and authorizes Los Gatos Family Dentistry to be reimbursed directly for all such claims. I understand that all payments/co-payments are due when treatment is rendered.

_____ _____
Signature of Financially Responsible Party *Date*

If same as above, skip to the Privacy Acknowledgement

WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____
Last First Relationship to Patient

SOCIAL SECURITY NO. _____ AGE:_____ BIRTHDATE: _____ PHONE #:_____

EMAIL: _____EMPLOYER NAME: _____ WORK PHONE #:_____

HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices dated March 1, 2008 and give my consent for use and disclosure of my protected health information as required by law. In addition, I authorize Los Gatos Family Dentistry to share my private health and dental information with the individuals listed below.

_____ _____
Signature of Patient *Date*

_____ _____ _____
Approved Individual *Approved Individual* *Approved Individual*

Los Gatos Family Dentistry
MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

	YES	NO	
Are you under a physician's care now?			if yes, please explain
Have you ever been hospitalized or had a major operation?			if yes, please explain
Have you ever had a serious head or neck injury?			if yes, please explain
Are you taking any medications, pills, or drugs?			if yes, please explain
Do you take, or have you taken, Phen-Fen or Redux?			if yes, please explain
Are you on a special diet?			if yes, please explain
Do you use tobacco?			if yes, please explain
Do you use controlled substances?			if yes, please explain

Women- are you Pregnant/trying to get pregnant? ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Local anesthetics ☐ Other if yes, please explain _____

Do you have any of the following:	YES	NO		YES	NO		YES	NO		YES	NO
Aids/HIV Positive			Cortisone Medicine			Hemophilia			Recent Weight Loss		
Alzheimer's Disease			Diabetes			Hepatitis A			Renal Dialysis		
Anaphylaxis			Drug Addiction			Hepatits B or C			Rheumatic Fever		
Anemia			Easily Winded			Herpes			Rheumantism		
Angina			Emphysema			High Blood Pressure			Scarlet Fever		
Arthritis/Gout			Epilepsy or Seizures			Hives or Rash			Shingles		
Artificial Heart Valve			Excessive Bleeding			Hypoglycemia			Sickle Cell Disease		
Artificial Joint			Excessive Thirst			Irregular Heartbeat			Sinus Trouble		
Asthma			Fainting/Dizziness			Kidney Problems			Spina Bifida		
Blood Disease			Frequent Cough			Leukemia			Stomach/Intestinal Disease		
Blood Transfusion			Frequent Diarrhea			Liver Disease			Stroke		
Breathing Problem			Frequent Headaches			Low Blood Pressure			Swelling of Limbs		
Bruise Easily			Gential Herpes			Lung Disease			Thyroid Disease		
Cancer			Glaucoma			Mitral Valve Prolapse			Tonsillitis		
Chemotherapy			Hay Fever			Osteoporosis			Tuberculosis		
Chest Pains			Heart Attack/Failure			Pain in Jaw Joints			Tumors or Growths		
Cold Sores/Fever Blisters			Heart Murmur			Parathyroid Disease			Ulcers		
Congential Heart Disorder			Heart Pace Maker			Psyciatric Care			Veneral Disease		
Convulsions			Heath Trouble/Disease			Radiation Treatments			Yellow Jaundice		

Do you have other medical conditions not covered above? If yes please explain _____
Comments:_____
_____

Medical Doctor Name:_____ Contact Phone:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (pr patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

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