Comfort Dentistry - *Dental Registration & History*

PATIENT INFORMATION

Date__________
Patient Name__________
SSN__________
Address__________
City__________ State_____ Zip_____
E-mail__________
Sex ☐M ☐F Age_____ Birth Date__________
☐Married ☐Widowed ☐Single ☐Minor
☐Separated ☐Divorced ☐Partnered
Occupation__________
Patient's Employer__________
Employer's Address__________
Employer's Phone__________
Spouse's Name__________
Spouse's Birth Date__________
Spouse's SSN__________
Spouse's Employer__________
If patient is a minor: Guardian's Name__________
☐Caretaker ☐P.O.A Name__________
Relationship to Patient __________
Guardian's Employer__________
Employers Address __________
Employers Phone __________
How did you hear about our office? ☐Insurance ☐Internet
☐Yellow Pages ☐Friend:________ ☐Other: ________

DENTAL INSURANCE

Insured's Name__________
Insured's Address__________
Birth Date__________
Relationship to Patient__________
Insurance ID#__________
Insurance Co.__________
Employer __________ Group #__________
Is patient covered by additional insurance? ☐Yes ☐No
If yes, Insured's Name: __________
Insured's Address__________
Birth Date__________
Relationship to Patient__________
Insurance ID#__________
Insurance Co.__________
Employer __________ Group #__________

Insurance Assignment
I certify that I, and/or my dependents(s), have insurance coverage

with__________________and assign directly to
Name of insurance company(ies)
Dr. Timothy J. McMahon all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

__________________ __________
Signature of Insured Date

HIPAA

Personal Health Information/HIPAA
The above named dentist may use my health care information and may disclose such information for treatment, payment and healthcare operations.

__________________ __________
Signature of Patient, Parent, Guardian or Personal Representative Date

I __________________, understand that I am financially responsible for all charges whether or not paid by insurance.

Signature__________________ Date__________

PHONE NUMBERS

Home (_____)__________ Work (_____)__________ Ext _____ Cell Phone (_____)__________
Spouse's Work (_____)__________ Alternate Phone (_____)__________ Relationship __________
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name__________ Relationship__________
Home Phone (_____)__________ Work Phone (_____)__________

DENTAL HISTORY

Patient Name ______________________ Today's Date ______________________
Reason for today's visit ______________________ Date of last dental visit ______________________
Former Dentist ______________________ Date of last dental x-rays ______________________
City/State ______________________ Date of last teeth cleaning ______________________

Family doctor's name? ______________________ Date of last visit ______________________
Other doctors name (Specialist)? ______________________ Date of last visit ______________________
Pharmacy ______________________

HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
Acid reflux	☐Yes	☐No
AIDS/HIV	☐Yes	☐No
Anaphylaxis	☐Yes	☐No
Anemia	☐Yes	☐No
Anxiety	☐Yes	☐No
Arthritis, rheumatism	☐Yes	☐No
Artificial heart valves	☐Yes	☐No
Artificial joints	☐Yes	☐No
Asthma	☐Yes	☐No
Atopic (allergy prone)	☐Yes	☐No
Back problems	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No
Blood disease	☐Yes	☐No
Cancer	☐Yes	☐No
Chemical dependency	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Circulatory problems	☐Yes	☐No
Congenital heart lesions	☐Yes	☐No
Cortisone treatments	☐Yes	☐No
Cough, persistent/bloody	☐Yes	☐No
Diabetes - type ________	☐Yes	☐No
Emphysema	☐Yes	☐No
Epilepsy	☐Yes	☐No
Fainting or dizziness	☐Yes	☐No
Food allergies	☐Yes	☐No
Gastric Bypass	☐Yes	☐No
Glaucoma	☐Yes	☐No
Headaches	☐Yes	☐No
Heart murmur	☐Yes	☐No
Heart problems	☐Yes	☐No
Describe ______________________		
Hemophilia	☐Yes	☐No
Hepatitis - type ________	☐Yes	☐No
Herpes	☐Yes	☐No
High/Low blood pressure	☐Yes	☐No
Jaundice	☐Yes	☐No
Jaw pain	☐Yes	☐No
Kidney disease	☐Yes	☐No
Lapband	☐Yes	☐No
Liver disease	☐Yes	☐No
Material allergies (latex, wool, metal, chemicals),	☐Yes	☐No
Mental illness	☐Yes	☐No
Mitral valve prolapse	☐Yes	☐No
Nervous problems	☐Yes	☐No
Nursing	☐Yes	☐No
Pacemaker	☐Yes	☐No
Pregnant Due Date _____	☐Yes	☐No
Psychiatric care	☐Yes	☐No
Radiation treatment	☐Yes	☐No
Rapid weight gain or loss	☐Yes	☐No
Respiratory disease	☐Yes	☐No
Rheumatic/Scarlet fever	☐Yes	☐No
Shingles	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Sinus trouble	☐Yes	☐No
Skin rash	☐Yes	☐No
Sleep Apnea / Snoring	☐Yes	☐No
Special diet	☐Yes	☐No
Spina Bifida	☐Yes	☐No
Stroke	☐Yes	☐No
Surgical implant	☐Yes	☐No
Swollen feet or ankles	☐Yes	☐No
Swollen neck glands	☐Yes	☐No
Thyroid problems	☐Yes	☐No
Tobacco habit	☐Yes	☐No
Tonsillitis	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Tumor or growth on head or neck	☐Yes	☐No
Ulcer/Colitis	☐Yes	☐No
Venereal disease	☐Yes	☐No

Other: ______________________

MEDICATIONS

List any medications you are currently taking:

☐ None

____

Place a mark on "YES or NO" to indicate if you have ever used these medications or are currently using now.

Medication	Yes	No
Fosamax -	☐Yes	☐No
Boniva -	☐Yes	☐No
Actonel -	☐Yes	☐No

DRUG ALLERGIES

List any drug allergies if any:

☐ None

____

CONSENT

I request and authorize Dr. Timothy J. McMahon and/or other persons as he may appoint, to perform or assist in the performance of dental treatment, procedures, and medication administrations as perscribed.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________________ Date ______________________ Relationship to Patient

I consent to the disclosure of my records (or my child's records) to the following person (s) who are involved in my care (or my child's care) or payment for the care.

____

____

My consent for disclosure of records shall be effective until revoked in writing.

3-01-06B