PATIENT NAME	DATE OF BIRTH	CIRCLE GENDER M F
MAILING ADDRESS	CITY, STATE, ZIP	
HOME PHONE	MOTHER'S NAME (IF MINOR)	FATHER'S NAME (IF MINOR)
CELL PHONE for appointment confirmation	WORK #	OTHER #
SSN:	RESPONSIBLE PARTY	

WERE YOU REFERRED TO THIS OFFICE? Y N IF YES, BY WHO? _____

IN CASE OF EMERGENCY , WHO MAY WE CONTACT? _____ PHONE _____

_____

DENTAL INSURANCE? Please circle: Y N IF YES, PLEASE PROVIDE INSURANCE CARD

APPOINTMENTS

I understand that if I fail to pay fees, keep appointments, or cancel appointments in less than 24 hours before their scheduled times, I may be dismissed as a patient at Three Forks Family Dentistry.

PAYMENT AND PRIVACY

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly/indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments & physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at 123 Main Street, Three Forks, Montana to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have read and filled out this PATIENT REGISTRATION AND CONSENT FORM to the best of my knowledge and it is complete and correct. I am consenting to treatment and agree to pay for all services rendered.

Signature: _____ Date: _____

HEALTH INFORMATION

1. Have you had any serious illness or operation? yes no
   Explain _____
   _____
   _____
   _____
   _____

2. Physician's
   Name: _____
   Phone: _____

MEDICAL HISTORY

ARE YOU ALLERGIC TO OR HAD A REACTION TO:

1. Local Anesthetic yes no
2. Penicillin or Other Antibiotics yes no
3. Sulfa Drugs yes no
4. Aspirin/Advil/Tylenol yes no
5. Codeine or Other Narcotics yes no
6. Metals (rings, earrings, etc.) yes no
7. Latex yes no
8. Other Allergies _____ yes no

DO YOU HAVE OR HAVE YOU HAD:

9. Diabetes yes no
10. High Blood Pressure yes no
11. Low Blood Pressure yes no
12. Heart Attack yes no
13. Heart Murmur (congenital heart disease) yes no
14. Heart Surgery (bypass, valve) yes no
15. Chest Pain Upon Exertion (angina) yes no
16. Rheumatic Heart Disease or Fever yes no
17. A Pacemaker yes no
18. Hepatitis (type A, B, Other) yes no
19. AIDS, ARC, HIV, ANTI-HIV yes no
20. Any Respiratory Disease/Asthma yes no
21. Do you use smokeless tobacco yes no
22. Do you smoke yes no
23. Blood Disorder or Anemia yes no
24. Abnormal Bleeding with Previous Extractions or Surgery yes no
25. Epilepsy, Convulsions, Fainting Spells or Dizziness yes no
26. Kidney Disease yes no
27. Stomach or Intestinal Trouble yes no
28. Liver Disease yes no
29. Joint Replacement yes no
30. Back or Neck Injury yes no
31. Radiation Therapy/Chemotherapy yes no

WOMEN:

32. Are You Pregnant yes no
33. Are You on Birth Control yes no

DENTAL HISTORY

1. Frequent Toothaches yes no
2. Periodontal (gum) Disease yes no
3. Difficulty in Opening or Closing Jaw yes no
4. Grinding or Clenching your Teeth yes no
5. Dry Mouth yes no
6. When were you last seen by a dentist? _____
7. Are you interested in whitening teeth? yes no
8. Are you interested in straightening teeth? yes no

Do you have any disease, condition or problem not listed? If so, please explain:

_____
_____
_____
_____

Please list any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____