



DANIEL J. PALM, DDS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:		First name:	Marital Status:	Today's Date:
Preferred name:	Parent/guardian name (if minor):	Date of Birth (DOB): - -	Age:	Sex: M or F
Address:		City:	State:	Zip:
Social Security Number (SSN):		Please check the best number to reach you at during the day:		
		<input type="checkbox"/> Home phone number:	<input type="checkbox"/> Work phone number:	<input type="checkbox"/> Cell phone number:
Other family members seen here (if applicable):	Who can we thank for referring you to our office?		Email address:	

INSURANCE INFORMATION

(Please present your insurance card to the receptionist.)

Person responsible for account:	Subscriber DOB: - -	Relationship to patient:	Cell phone #:
Is this person a patient here?	Subscriber employer:		Subscriber SSN:
Insurance provider:	Group #:		Member #:

IN CASE OF EMERGENCY PLEASE CONTACT:

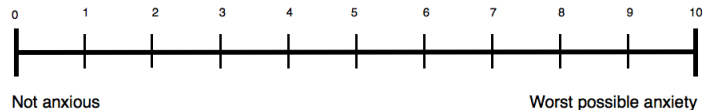
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Cell phone #:
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DENTAL HISTORY:

Please briefly explain your present dental problems, concerns or desires: _____

Date of last dental visit _____
 Date of last dental cleaning _____
 Date of last dental x-rays _____
 How often do you brush your teeth? _____ Floss? _____

Please mark your current level of dental anxiety:



Have you ever been prescribed antibiotics by a doctor/dentist prior to dental treatment or teeth cleaning? Yes No

Have you ever had a bad dental experience? Yes No If so, please explain: _____

Who was your previous dentist? _____

HEALTH HISTORY

What is the reason for today's visit? How can we help you?

Are you currently under the care of a physician? Whom?

Allergies? (e.g. Penicillin, Epinephrine, metal)

Have you ever taken bisphosphonates (oral or IV) for osteoporosis? (e.g. Boniva, Fosamax, Actonel)

Have you ever had problems with abnormal bleeding?

Have you ever had any complications due to local or general anesthesia?

Have you EVER or CURRENTLY have:

Joint Replacement	Yes	No	Rheumatic heart disease	Yes	No
Heart ailment/ disease	Yes	No	Bacterial Endocarditis	Yes	No
Heart attack	Yes	No	Stroke	Yes	No
Angina	Yes	No	Fainting, Dizziness	Yes	No
Congestive Heart Failure	Yes	No	Shortness of breath	Yes	No
Pacemaker/ Defibrillator	Yes	No	Diabetes	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
High/low blood pressure	Yes	No	Hepatitis A, B, C (circle one)	Yes	No
Liver trouble, jaundice	Yes	No	Alzheimer's/ Dementia	Yes	No
Kidney trouble	Yes	No	Osteoporosis	Yes	No
Anemia, Leukemia, Low Platelets	Yes	No	Sleep apnea/ use a CPAP machine	Yes	No
Asthma, Hay Fever	Yes	No	Glaucoma	Yes	No
Autoimmune disease	Yes	No	Psychiatric treatment	Yes	No
Arthritis/ Gout	Yes	No	Frequent headaches/migraines	Yes	No
Epilepsy, convulsions	Yes	No	Artificial Valve	Yes	No
Rheumatic Fever	Yes	No	HIV/AIDS	Yes	No
Thyroid trouble	Yes	No	Cancer	Yes	No
Eczema, Hives	Yes	No	Tobacco	Yes	No
Recreational drug use	Yes	No	GERD	Yes	No

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

Please list all current medications: _____

Vitamins/Supplements: _____

Hospitalizations/ Surgeries: _____

FEMALES:

Are you currently pregnant? Yes No

Do you plan on being pregnant soon? Yes No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Palm Family Dentistry or insurance company to release any information required to process my claims. I also acknowledge that I have been offered a copy of the office's "Notice of Privacy Practices".

Patient/Guardian signature

Date



When you return this form to the receptionist, **please bring your insurance card**. It is important that we always have your **current** and **accurate** insurance information to bill your insurance and *are not responsible* for any unpaid claims due to not having been informed of changes in employment and/or insurance benefits.

As a courtesy to you, we will bill your insurance company for the services provided. **All co-payments and unsatisfied deductibles must be paid at the time of service**; our office expects payment in full from your insurance within 45 days unless otherwise specified by a contract with your insurance provider. In the event that your insurance makes payment at a later date, all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage, including any legal or other cost incurred in the collection of this account should it become delinquent. I authorize Palm Family Dentistry to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to

Signed: _____

Date: _____

Acknowledgement of Receipt of Privacy Notice
Effective March 27, 2019

I have been presented with a copy of Palm Family Dentistry **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information.

Signed: _____

Date: _____

The person listed below has my permission to discuss my medical information:

Printed Name: _____

DOB: _____

List 4 digits of SSN: _____