PALM FAMILY DENTISTRY

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:** | | |
| | ☐ Home phone number: | ☐ Work phone number: | ☐ 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 #: |

## 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:

0 1 2 3 4 5 6 7 8 9 10

Not anxious — Worst possible 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**

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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:**_____