PATIENT REGISTRATION

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Full Name:			Name you wish to be called:
Social Security #:		Date of Birth:	
Mailing Address:			Zip Code:
Home Phone #:		Cell Phone #:	
Age:	Gender:	Race:	Referred By:
Employer/School Name:			Work Phone #:
Marital Status: S M W D SEP			
Email Address:			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, undersigned, for myself or a minor child or another person for whom I have authority to sign, certify that the insurance information listed above is correct and that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney fees.

Signature: _____ Date: _____

Should an employee be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne disease (eg. HIV, Hepatitis, etc.) or other communicable diseases; I consent to provide samples of my blood or body fluid to be tested for evidence of infection. I also understand that Dr. Stoddard and employees are obligated to submit to blood tests for certain infectious diseases (eg. HIV, Hepatitis, etc.) if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the office.

Signature: _____ Date: _____

DENTAL HISTORY

Dental complaint at this moment: _____

_____

Date of your last dental treatment: ____/____/____ Last Cleaning: ____/____/____

Do you grind or clench your teeth? ..... Yes / No

Pain in jaw joint? ..... Yes / No

Sore or sensitive teeth? ..... Yes / No

Do your gums bleed? ..... Yes / No

Cold or canker sores? ..... Yes / No

Unpleasant taste? ..... Yes / No

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GENERAL HEALTH HISTORY

Are you in good health? ..... Yes / No
If no, explain: _____

_____

Are you under a physician's care now? ..... Yes / No
If yes, explain: _____

_____

Name of Physician: _____ City: _____ Phone: _____

Are you taking any drugs or medications? ..... Yes / No
If yes, please list: _____

_____

_____

Are you sensitive or allergic to any drugs? ..... Yes / No
If yes, please list: _____

_____

_____

Have you been hospitalized in the past two years? ..... Yes / No
If yes, please explain: _____

_____

_____

DO YOU NOW HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HIV ..... Yes / No
Allergies ..... Yes / No
Anemia ..... Yes / No
Asthma or Hay Fever ..... Yes / No
Blood Diseases ..... Yes / No
Cancer ..... Yes / No
Diabetes ..... Yes / No
Epilepsy ..... Yes / No
Excessive Bleeding ..... Yes / No
Fainting Spells or Seizures ..... Yes / No
Heart Disease ..... Yes / No
Heart Murmur ..... Yes / No
Herpes ..... Yes / No
Hepatitis ..... Yes / No
High Blood Pressure ..... Yes / No
Kidney Disease ..... Yes / No
Liver Disease ..... Yes / No
Radiation Treatment ..... Yes / No
Rheumatic Fever ..... Yes / No
Rheumatism or Arthritis ..... Yes / No
Stroke ..... Yes / No
Stomach Ulcers ..... Yes / No
Tuberculosis ..... Yes / No
Venereal Disease ..... Yes / No

Do you have any artificial joints or heart valves? ..... Yes / No
Do you have any disease, condition, or problem not listed? ..... Yes / No
WOMEN: Are you pregnant? ..... Yes / No
If yes, due date: _____
Are you taking birth control pills? ..... Yes / No

THE ABOVE INFORMATION IS TRUE AND I WILL NOTIFY YOU OF ANY CHANGES.

Signature: _____ Date: _____
In case of emergency, contact: _____ Phone: _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family such as their spouse, significant other, parent or children to call and request the results of procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent.

I authorize **Stoddard Dental Group** to release my records and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

AUTHORIZATION REGARDING MESSAGES

(please check all that apply)

___ I authorize you to leave a detailed message on my home or cell number regarding appointments.

___ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

___ I authorize you to leave a message with anyone who answers the phone.

___ Messages may only be left with: _____

_____

Patient Name (Please PRINT)

_____

Patient Signature

_____

Date

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