

AARON CARNER, D.M.D., L.L.C.

PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT NAME, LAST	FIRST	MIDDLE	BIRTHDATE	AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS (Circle One) M S W D	TODAY'S DATE
PATIENT ADDRESS		P.O. BOX	CITY		STATE	ZIP CODE	PHARMACY NAME
HOME PHONE NUMBER	CELL PHONE NUMBER		EMPLOYER NAME		EMPLOYER PHONE NO.	EXT.	OCCUPATION
PRIMARY INSURANCE COMPANY / PRIMARY DENTAL INSURANCE					GROUP NUMBER		
SUBSCRIBER'S NAME			SUBSCRIBER D.O.B.		SOCIAL SECURITY NO.		
SECONDARY INSURANCE COMPANY					GROUP NUMBER		
SUBSCRIBER'S NAME					SOCIAL SECURITY NO.		
I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.							
X _____							
I HEREBY AUTHORIZE PAYMENT TO THE DENTIST OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.							
X _____							
MEDICAL HISTORY - DO YOU HAVE OR HAVE YOU ANY OF THE FOLLOWING ()							
ASTHMA		EMPHYSEMA		PNEUMONIA		Please Check and that apply <input type="checkbox"/> Smoke <input type="checkbox"/> Drink <input type="checkbox"/> Drugs <input type="checkbox"/> Been Exposed to HIV <input type="checkbox"/> Excessive Bleeder <input type="checkbox"/> Pregnant	
BLEEDING PROBLEM		HEART ATTACK <small>WHEN</small> / /		POOR CIRCULATION			
BLOOD TRANSFUSION		HEART MURMUR		SHORTNESS OF BREATH			
BRONCHITIS		HEPATITIS/LIVER DISEASE		STOMACH OR BOWEL PROBLEM			
COUGH/COLDS		HIGH BLOOD PRESSURE		TUBERCULOSIS (TB)			
DIABETES		IRREGULAR HEART BEAT		THYROID OR GOITER PROBLEM			
Problem with Local Anesthesia		KIDNEY OR BLADDER PROBLEM		ANEMIA			
KIDNEY DISEASE		MITRAL VALVE PROLAPSE		PSYCHIATRIC CARE			
ANTIBIOTIC before dental appointment		JOINT REPLACEMENT		PACEMAKER			
MEDICATIONS IN THE LAST SIX MONTH HAVE YOU: TAKEN ANY OF THE FOLLOWING:							
<input type="checkbox"/> ANTIBIOTICS	<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> BLOOD PRESSURE	<input type="checkbox"/> CORTISONE	<input type="checkbox"/> HEART PILL	<input type="checkbox"/> STEROIDS	<input type="checkbox"/> TRANQUILIZERS	
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> BIRTH CONTROL PILLS	<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> DIABETIC PILL	<input type="checkbox"/> HORMONES	<input type="checkbox"/> THYROID	<input type="checkbox"/> WATER PILL	
Current Medications _____							
Please list all medication you are allergic to or can't take: _____							

Recent exposure to communicable disease Yes No If so, what? _____

Are there any disorders or diseases that run in your family? Specify: _____

Physician: _____ Being Treated For: _____

Previous Surgery: _____

Referred by: _____ Dentist: _____ Address: _____

Date of last visit to Dentist _____ General Health now _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

NOTES:

How long have you been seeing present dentist? _____
Any gaps in treatment? _____
Last cleaning? _____
Any problem areas? _____
Pain or discomfort? _____
Had previous Perio care? _____
When? _____
Who? _____
Surgery? _____

Extraoral/TMJ _____

Intraoral _____

Notes _____

