

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Patient is : Responsible Party Policy Holder Dependent: Child / Spouse / Other: _____

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth date: _____ Social Security #: _____ Drivers Lic#: _____
Responsible Party is: Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth date: _____ Social Security #: _____ Drivers Lic#: _____
Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Patient Information (section 2):

Employment Status: Full Time Part Time Self Employed Retired Unemployed
Student Status: Full Time Part Time
Preferred Pharmacy: _____ Preferred Dentist: _____
Referred By: _____

Primary Insurance Information:

Name of Subscriber: _____ Relationship to Insured: Self Spouse Child Other
Subscriber ID: _____ Group ID: _____
Subscriber's Social Security #: _____ Subscriber's Birth date: _____
Employer/Group Name: _____ Insurance Company: _____
Address: _____
City, State, Zip: _____ Ins Phone: _____

Secondary Insurance Information:

Name of Subscriber: _____ Relationship to Insured: Self Spouse Child Other
Subscriber ID: _____ Group ID: _____
Subscriber's Social Security #: _____ Subscriber's Birth date: _____
Employer/Group Name: _____ Insurance Company: _____
Address: _____
City, State, Zip: _____ Ins Phone: _____

MEDICAL HISTORY

PATIENT NAME _____

BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you have well water at home?	Yes	No	

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Local Anesthetics
Other	If yes, please explain: _____					

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Scott P. Taylor & Associates

HIPAA/General Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to the use and/or disclosure of my protected health information by Scott P. Taylor, DDS, PC for the purposes of treatment, payment and healthcare operations.

I understand that protected health information includes the following:

- Health records describing my health history, symptoms
- Demographic information
- Examination and test results
- Diagnosis
- Treatment
- Plans for future medical care

And that this information serves as:

- A means for communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A basis for diagnosing and planning my care and treatments
- A means by which a third party can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand that:

1. Scott P. Taylor, DDS, PC originates and maintains protected health information as part of my healthcare, including but not limited to information that may have been obtained from another healthcare provider, clearinghouse, health plan or employer.
2. I have the right to review Scott P. Taylor, DDS, PC's Notice of Privacy Practices (which describes Scott P. Taylor, DDS, PC's protected health information use and disclosure practices) before I sign this document.
3. I have the right to request a restriction as to how my protected health information is used to carry out treatment, payment or health care operations, however, Scott P. Taylor, DDS, PC is not required to agree to the restrictions requested.
4. I have the right to revoke this consent at any time in writing. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
5. Scott P. Taylor, DDS, PC reserves the right to change Notice of Privacy Practices at any time. I have the right to obtain a copy of any revised notice upon request.

Restrictions:

No restrictions requested

I request the following restriction(s) on the use or disclosure of my health information:

Patient Name (printed): _____

Signature of Patient or Parent/Legal Guardian

Date

If Parent/Legal Guardian Signed, then Printed Name Here

Relationship to Patient (if applicable)

Restriction Accepted Denied

FOR OFFICE USE ONLY