HARRIS
FAMILY DENTISTRY

PATIENT REGISTRATION

First Name: _____ Last Name: _____

Middle Initial: _____ Preferred Name: _____ Student Status: Full Time: ___ Part Time: ___

◯ Male ◯ Female Birthdate: _____/_____/_____ Soc Sec: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed Pharmacy: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Position: _____

Whom may we thank for referring you to our office? Friend's name _____ ◯ Internet ◯ Drove by

◯ Facebook Other: _____

Previous Dentist: _____ Phone: _____

City and State of Previous Dentist: _____ Last Dental Exam: _____

Patient is Responsible Party ◯ Yes ◯ No if not, :

Responsible Party Name: _____ Date of Birth: _____/_____/_____

Address if different than patient, Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Position: _____

Primary Insurance Information: Relationship to patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Name: _____ Insured birthdate: _____/_____/_____

Employer: _____ Phone: _____

Insurance Carrier: _____ Group Number: _____

Id # or Soc Sec: _____ Insurance Phone:_____

Thank you for choosing us as your dental provider!

MEDICAL HISTORY

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

Are you under a physicians care now? ◯ Yes ◯ No If yes, _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, _____

Do you use tobacco? ◯ Yes ◯ No ◯ Cigarettes ◯ Smokeless Times per day? _____

Do you use controlled substances? ◯ Yes ◯ No if yes, _____

Current Medications: _____

_____

Are you taking blood thinners? ◯ Yes ◯ No Are you taking or ever taken Bisphosphonates? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Latex ◯ Metal ◯ Sulfa Drugs ◯ Local Anesthetics

Other Allergies: _____

Women are you ◯ Pregnant/trying to get pregnant ◯ Nursing ◯ Taking oral contraceptives?

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

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

If you said yes to heart attack, cancer or stroke, please list details and dates:_____

_____

To the best of my knowledge, the above questions have been accurately answered. I understand 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.

X _____ Date: _____

Harris Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Harris Family Dentistry_____

Telephone: 706-216-7777 Fax: 706-216-6478_____

E-mail: welcome@harrisfamilydentistry.com

Address: 212 Prominence Court Dawsonville, GA 30534

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Consent to Obtain Medical Records:

I hereby authorize Harris Family Dentistry to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Consent to Release Medical Information and/or Records to a Spouse, Family Member or Significant Other:

I hereby authorize Harris Family Dentistry to release and information contained in my medical record to the persons listed:

1)_____2)_____ 3)_____

**If you do not authorize information to be released to anyone please circle this statement.*

I do not authorize any information to be released to anyone other than myself.

I hereby authorize messages to be left on a voice mail system or answering machine numbers listed on the patient information form.

Acknowledgement of Privacy Rights:

By signing below, I acknowledge that the notice of Privacy Practices and Individual Rights has been made available.

I acknowledge I have read the above, am giving my consent to the above and am acknowledging I have been informed of my rights to privacy.

Signature:_____ Date:_____