



REGISTRATION AND TREATMENT

Cell Phone _____

Date _____ Email _____ Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec # _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____
Last Name First Name Middle Initial

Relation to patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

DENTAL HISTORY

Reason for today's visit _____

Previous Dentist _____

Address _____

Date of last dental care _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Is there anything you dislike or would like to change about your teeth, bite or smile? _____

Check (√) if you have had problems with any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot and/or cold | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Sensitivity to biting | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Clicking/popping jaw | <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in your mouth |

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

 Have you had any serious illnesses or operations? Yes No If yes, describe _____

 Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

 (Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (√) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | Describe _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Glaucoma | Describe _____ | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> C Pap/Sleep Apnea |

 If you checked yes to any of the above- are you taking any medication? Yes No

 How well-controlled is it? Well-controlled without medication Well-controlled with medication Not controlled

MEDICATIONS

ALLERGIES

DENTAL HISTORY

- I authorize my insurance company to pay to the dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

- I authorize the dentist to release all information necessary to secure the payment of benefits.

- I understand that I am financially responsible for all charges whether or not they are paid for by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

CRESTVIEW FAMILY DENTAL, LLC

**PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION
DISCLOSURE FORM**

I. Acknowledge of Practice’s Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person’s involvement with my health care of payment relating to my health care.

Print Name: _____ Home Phone: _____ Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

Print Name: _____ Home Phone: _____ Cell Phone: _____

CRESTVIEW FAMILY DENTAL, LLC
PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION
DICLOSURE FORM 2

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by alternative means that I have listed below.

Home Telephone Number:

Written Communication Address:

____ OK to leave message with detailed information ____ OK to mail to address listed above

____ Leave message with call back numbers only ____ E-mail me at: _____

Work Telephone Number:

Fax Communication:

____ OK to leave message with detailed information ____ OK to Fax at the number listed above

____ Leave message with call back numbers only ____ E-mail me at: _____

Other: _____

Name of Patient (Print)

Signature

Date

Witness: _____ **Date** _____