PATIENT REGISTRATION

Welcome! So that we may provide you with the best possible care please complete **ALL PAGES** of the following **Registration, Medical** and **Dental History Forms.**

> **ALL INFORMATION IS COMPLETELY CONFIDENTIAL** <

1 PERSONAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

Date				
Last Name		First		MI
Preferred name to be called by				
Address				
City		State		ZIP
Home Phone No.		Fax		
Cell		Email		
Birthdate	Age	Male	Female	
Married	Single	Partnered	Divorced	Widowed
Social Security No.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

Date				
Last Name		First		MI
Preferred name to be called by				
Address				
City		State		ZIP
Home Phone No.		Fax		
Cell		Email		
Birthdate	Age	Male	Female	
School			Grade	
Social Security No.				

NOTE: *If your child's last name and/or address are not the same as yours, please fill in the top box.*

2 DENTAL INSURANCE

PRIMARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID No.	
Insured's Social Security No.	

SECONDARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID No.	
Insured's Social Security No.	

3 GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?		
Name	Relationship	
You were referred to us by		
Your Former Address		
City	State	Zip
Person to contact for emergency		
Phone Number		
Address		
City	State	Zip
Closest relative not living with you		
Phone Number		
Address		
City	State	Zip

4 ACCOUNT INFORMATION

Person financially responsible for account		
Name		
Relationship to Patient	Social Security No.	
Address		
City	State	Zip
Phone No.		
YOU		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax	
YOUR SPOUSE/PARTNER		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax	

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

(please circle)

1. Have you been under the care of a medical doctor during the past two years? .... YES NO
   If yes, for what? ____________
   Physician's Name ____________ Phone ____________
   Address ____________ City ____________ State ______ Zip ______
2. Have you ever taken any medication or drugs during the past two years? .... YES NO
3. Are you taking any medications or drugs currently, including regular doses or aspirin or over the counter herbal medicines? .... YES NO
   If yes, please list name and dosage. ____________
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen *(fenfluramine-phentermine)*; Pondimen *(fenfluramine)*; and Redux *(dexfenfluramine)*? .... YES NO
   If yes to the above, did you have a medical exam for heart issues? .... YES NO
5. Are you aware of having an allergic *(or adverse)* reaction to any medication or substance? .... YES NO
   If yes, please list: ____________
6. Have you been a patient in the hospital during the past five years? .... YES NO
7. Indicate which of the following you have had, or have at present. *(please circle "yes" or "no" to each item.)*

Condition			Condition			Condition		
Heart *(Surgery, Disease, Attack)*	YES	NO	Ulcers	YES	NO	Hepatitis **A B C** *(circle one)*	YES	NO
Chest Pain	YES	NO	Diabetes	YES	NO	Veneral Disease	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Contact Lenses	YES	NO	Cold Sores/Fever Blisters	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Blood Transfusions	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Arthritis/Rheumatism	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Cortisone Medicine	YES	NO	Latex Sensitivity	YES	NO	Yellow Jaundice	YES	NO
Swollen Ankles	YES	NO	Allergies or Hives	YES	NO	Neurological Disorders	YES	NO
Stroke	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Diet *(Special/Restricted)*	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Artificial Joints *(hip, knee, etc...)*	YES	NO	Chemotherapy	YES	NO	Nervous/Anxious	YES	NO
Kidney Trouble	YES	NO	Tumors	YES	NO	Psychiatric/Physiological Care	YES	NO

8. Do you use more than two pillows to sleep? .... YES NO
9. Have you lost or gained more than 10 pounds in the last year? .... YES NO
10. Do you have or have you had any disease condition or problem not listed? .... YES NO
    If yes, please list: ____________
11. **Women:** Are you pregnant or think you may be pregnant? *(please circle)* **YES** ____ months, **NO** **NURSING?** .... YES NO
12. **Women:** Do you use birth control medications? .... YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health.

Patient Signature ____________ **Date** ____________

HISTORY REVIEW

Dentist Signature ____________ **Date** ____________

DENTAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

What is the reason for your visit today? ______________________

Date of Last Dental Visit ________ **Last Dental Cleaning** ________ **Last Full Mouth X-rays** ________

What was done on your last dental visit? ______________________

Previous Dentist's Name ______________________

Address ______________________ State ________ Zip ________

Telephone ______________________

How often do you have dental examinations? ______________________

How often do you brush your teeth? ________ How often do you floss? ________

What other dental aids do you use? *(interplak, toothpick, etc...)* ______________________

Do you have any dental problems now? *(please circle)* **YES** **NO**

If yes, please describe: ______________________

Are any of your teeth sensitive to: *(please circle)*

Hot or Cold?	**YES**	**NO**
Sweets?	**YES**	**NO**
Biting or Chewing?	**YES**	**NO**
Have you noticed any mouth oders or bad tastes?	**YES**	**NO**
Do you frequently get cold sores, blisters or any other oral lesions?	**YES**	**NO**
Do your gums bleed or hurt?	**YES**	**NO**
Have your parents experienced gum disease or tooth loss?	**YES**	**NO**
Have you noticed any loose teeth or change in your bite?	**YES**	**NO**
Does food tend to become caught between your teeth?	**YES**	**NO**

If yes, where? ______________________

Do You: *(please circle)*

Clench or grind your teeth while awake or asleep?	**YES**	**NO**
Bite your lips or cheeks regularly?	**YES**	**NO**
Hold foreign objects with your teeth? *(pencils, pipe, pins, nails, fingernails, etc...)*	**YES**	**NO**
Mouth breathe while awake or asleep?	**YES**	**NO**
Have tired jaws, especially in the morning?	**YES**	**NO**
Snore or have any other sleeping disorders?	**YES**	**NO**
Smoke/chew tobacco or use other tobacco products?	**YES**	**NO**

Is there anything else about having dental treatment that you would like us to know ? If yes, please describe. **YES** **NO**

____

Have you ever had: *(please circle)*

Orthodontic Treatment?	**YES**	**NO**
Oral Surgery?	**YES**	**NO**
Periodontal Treatment?	**YES**	**NO**
Your teeth ground or bite adjusted?	**YES**	**NO**
A bite plate or mouth guard?	**YES**	**NO**
A serious injury to the mouth or head?	**YES**	**NO**

If so, please describe, including cause.

____

Have you experienced: *(please circle)*

Clicking or popping of the jaw?	**YES**	**NO**
Pain? *(joint, ear, side of face)*	**YES**	**NO**
Difficulty in opening or closing the mouth?	**YES**	**NO**
Difficulty on chewing on either side of the mouth?	**YES**	**NO**
Headaches, neck pain or shoulder aches?	**YES**	**NO**
Sore muscles? *(neck, shoulders)*	**YES**	**NO**

Are you satisfied with the appearance of your teeth?	**YES**	**NO**
Would you like to keep all of your teeth all of your life?	**YES**	**NO**
Do you feel nervous about having dental treatment?	**YES**	**NO**

If so, what is your biggest concern? ______________________

Have you ever had an upsetting dental experience? **YES** **NO**

If so, please describe? ______________________

RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received a Notice of Privacy Practices from Dr. Keith W. Cowhey, D.D.S. and/or his staff.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of *(name of patient)* ____________________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use if anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of an oral, written or electronic health records that are individually identifiable as mine for the purpose if carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates. I understand that a 1.5% late charge (18% APR) may be added to my account. If required I also understand a check of my credit history may be made.

Patient's Signature ________________________ Date __________ Witness ________________

Parent/Responsible Party's Signature ________________________ Relationship to Patient ________________