## PATIENT REGISTRATION

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Status: Full Time Part Time  Medicaid ID: Pref. Dentist:  Employer ID: Pref. Hyg:  Primary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other  Insured Soc. Sec: Insured Birth Date:  Employer: Address 2: Address 2: City, State, Zip:  Rem. Benefits: Rem. Deduct:  Relationship to Insured: Self Spouse Child Other  Relationship to Insured: Self Spouse Child Other  Insured Soc. Sec: Insured Birth Date: Self Spouse Child Self Secondary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other  Insured Soc. Sec: Insured Birth Date: Self Secondary Insurance Information  Name of Insured: Relationship to Insured: Self Secondary Secondary Insured: Self Secondary Secondary Insured: Self Secondary Secondary Insured: Self Secondary Secondary Secondary Secondary Insured Secondary Se	1600.0			<u> </u>		- Section 3 -
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## **MEDICAL HISTORY**

PATIENT NAI	ME		Birth Date	
				ody. Health problems that you may eceive. Thank you for answering the
lave you ever been hospital Have you ever had Are you taking ar Do you take, or have yo	under a physician's care now? lized or had a major operation? a serious head or neck injury? ny medications, pills, or drugs? ou taken, Phen-Fen or Redux?	Yes No If yes, pl Yes No	ease explain: ease explain: ease explain:	
Do y	samax, Boniva, Actonel or any scontaining bisphosphonates?  Are you on a special diet?  Do you use tobacco?  ou use controlled substances?	Yes O No	Vomen: Are you Pregnant/Trying to get pre Taking oral contraceptives	
Are you allergic to any of t Aspirin Penic Other If yes, please	cillin Codeine	Acrylic Metal	Latex Local A	nesthetics Sulfa Drugs
Do you have, or have you AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy	had, any of the following?  Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea	Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash	Hypoglycernia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis	Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice
Have you ever had any ser Comments:	ious illness not listed above?(	Yes No If yes, pleas	se explain:	
		have been accurately answe lity to inform the dental offic	ered. I understand that providir e of any changes in medical st	
SIGNATURE OF PATIENT,	PARENT, or GUARDIAN		<u>.                                      </u>	DATE

Please tell us <b>why</b> you are here today?			
	· · · · · · · · · · · · · · · · · · ·		
Your current dental health is	Good	Fair	Poor
Do you require antibiotics before dental			
treatment?	Yes	No	
Are you currently in pain?	Yes	No	
Have you ever had serious/difficult problems			•
associated with any previous dental work?	Yes	No	
Do you like your smile?	Yes	No	
Do your gums bleed?	Yes	No	
Have you ever had periodontal disease?	Yes	No	
How many times a week do you floss?	·		
How many times a day do you brush?			
Type of bristles?	Hard	Medium	Soft
Date of last dental visit?			
How did you hear about our office?			
I affirm that all medical information that I have health is correct and accurate to the best of mused and relied upon by Four Flags Family Developeresponsibility to accurately and timely informe each and every visit. I further acknowledge the provided may not be accurate and that I will be to the treatment, products or services I am to understand that I am responsible for verifying insurance policies which may cover said cost, Family Dentistry has provided me with in regain to be accurate and are not to be relied upon signing below I am agreeing to the above state Family Dentistry to perform any necessary detereatment with my informed consent.	my knowledge intistry in proven this office of nat the estimate be responsible or receive by any of the benefits, and acknowle ards to my inside in making my red conditions	, I understand the riding my treatment any and all change ted cost for treatment, in full, for any and through Four Fourages or limited that any estimate benefits a consent decision and that I am au	at this information will be ent and agree that it is my ges in my medical status at them which I have been and all charges that relate flags Family Dentistry. I hitations of any and all imates that Four Flags are as a courtesy and may as. I acknowledge that by thorizing Four Flags
Signature		Date	

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help!

## FOUR FLAGS FAMILY DENTISTRY 24 N St Joseph Ave Ste, E2 269-683-4180 269-683-5875

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

THE CHIMATION	
Parent or Guardian name if under 40	
t aront or oddition hame if under 18	
. adolt address	
Patient phone number	
carry out treatment, payment activities, and healthcare operations.	•
Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before consent. Our notice provides a description of our treatment, payment activities, and healthcapperations, of the uses and disclosures we may make of your protected health information, a important matters about your protected health information.	are and of other
We reserve the right to change our privacy practices as described in our Notice of Privacy Privacy our notice, we will issue a revised copy which will contain its changes.	ractices. If we
You may obtain a copy of our Notice of Privacy Practices at any time by contacting:	
Four Flags Family Dentistry Staff	
269-683-4180	
Right to Revoke: You will have the right to revoke this consent at any time by giving us writte your revocation submitted to the office.	n notice of
SIGNATURE	
<u>                                     </u>	
I,	unity to read rstand that ed health
Signature: Date:	
It is completely your decision whether or not to sign this authorization form. We cannot refuse if you choose not to sign this authorization.	to treat you
In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, s federal law changes this possibility.	
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUT THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.	HORIZE
Patient or Guardian Signature  f you are signing as a personal representative of the patient, describe your relationship to the he source of your authority to sign this form:	
Relationship to PatientPrint Name	
THE MAINE	