MOOREHEAD
FAMILY DENTISTRY

Patient Registration

Patient Name:	Preferred Name:	Date:	
Home Address:	City:	State:	Zip:
☐ Home address and home phone # are same for entire family			
Cell Phone #:	Home Phone #:	Work Phone #:	
Social Security #:	DOB:	Gender: ☐ Male ☐ Female ☐ _____	
Email Address:			
Place of Employment:			
Who referred you/Where did you hear about us?			
Emergency Contact Name:	Relationship:	Phone #:	

Insurance Information

Is the patient using dental insurance? If yes, please fill out the following.

Insurance Carrier:	Insurance Company Phone #:
Subscriber ID:	Group #:
Patient's relationship to the subscriber: ☐ Self ☐ Spouse ☐ Child	

If the subscriber is not the patient, please fill out the subscriber info below.

Subscriber's Full Name: first	last	middle initial	Preferred Name:
Subscriber's Address: street	city	state	zip
Subscriber's DOB:	Social Security #:		
Subscriber's Place of Employment:			
Is there a second dental insurance plan that the patient will be using? Yes No			

Parent/Guarantor Information

If person resposnsible for account is different than patient or subscriber above, please fill out this section.

Full Name: first	last	middle initial	Preferred Name:
Home Address: street	city	state	zip
Cell Phone #:	Home Phone #:		
Email Address:	Social Security #:		
Place of Employment:			
Work Address: street	city	state	zip
Work Phone:			

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Health History Form

Patient Name:	Phone:
Primary Care & Specialty Physician(s): [cardiologist, OBGYN, etc)	Last Visit Date(s):

Medical Information

Please mark (X) your response to indicate if you have had any of the following diseases or problems.

	Yes		Yes		Yes		Yes
Cardiovascular		**Nervous System**		**Respiratory**		**Endocrine**	
CAD (angina, heart attack)	☐	Seizures/Epilepsy	☐	COPD	☐	Thyroid Disorders	☐
Heart Failure (weak heart)	☐	Depression or Panic Attacks	☐	Emphysema	☐	Diabetes Mellitus	☐
High Blood Pressure	☐	Psychosis or Mania	☐	Chronic Bronchitis	☐	Immune Disorder	☐
Low Blood Pressure	☐	Multiple Sclerosis	☐	Asthma	☐	Pregnant (due date: _____)	☐
Arrhythmias (irregular beat)	☐	Headaches/Migraine	☐	Sinus/Hay Fever	☐	Breast Feeding	☐
Congenital Heart Defect	☐	Substance Abuse	☐	Obstructive Sleep	☐		
Valve Disease or Murmur	☐	Alzheimer's/other Dementia	☐			**Excretory**	
Artificial Heart Valve	☐	Physical/Mental Impairment	☐	**Miscellaneous**		Liver Disorder (noninfectious)	☐
Endocarditis (Heart Infection)	☐	**Infections**		Cancer	☐	Kidney Disorder	☐
Stroke or TIA	☐	Hepatitis	☐	Joint Replacements	☐	Bladder Disorder	☐
Bleeding Problems	☐	HIV/AIDS	☐	Organ Transplant	☐	Ulcers or GERD	☐
Blood Cell Disorders	☐	Tuberculosis	☐	Glaucoma	☐	Intestinal Problems	☐

Please list any medical problems you have that are not listed in this table:

Have you ever recieved a local anesthetic? Y/N A general anesthetic? Y/N Any problems? Y/N

Please list all allergies to medications, foods or any other substances:

Please list ALL medications you are taking, including non-prescription products:

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes		Yes
Do you gums bleed when you brush your teeth?	☐	Have you ever been told that you snore or have sleep apnea?	☐
Have you ever had gum problems or gum surgery?	☐	Have you ever lost any teeth?	☐
Do you have any clicking, popping, or discomfort in your jaw?	☐	Have you replaced the missing teeth with anything?	☐

How can we best serve you at your appointment?

What type of dental treatment have you had in the past? Why was it done?

Have you ever had a negative experience in the dental office?

On a scale of 1-10 (10 being highest level) what is your level of anxiousness with the idea of having dental work completed?

On a scale of 1-10 (10 being extremely important) how important is it for you to keep all your teeth for a lifetime?

What improvements would you make in your teeth if you could change anything?

What are factors that would make a dental office excellent in your mind?

Is there anything that would stand in your way of getting the proper dentistry you need?

Do you have any time constraints for the completion of any dentistry that you may need?

Patient Signature:

_____ Date: _____

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Insurance Release and Authorization

I hereby authorize Moorehead Family Dentistry to release any information regarding any insurance claim, to my insurance company for the purpose of determining benefits for myself and/or dependants.

_____

Patient or Parent/Guardian Signature

I also authorize payment directly to Moorehead Family Dentistry for benefits otherwise payable to me, for myself and/or dpeendants.

_____

Patient or Parent/Guardian Signature

Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Moorehead Family Dentistry may use & disclose my protected heath information. I understand that Moorehead Family Dentistry reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Patient Name: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Office Use Only: To be completed only when a patient declines to sign acknowledgement.

Check here if patient or Parent/Guardian declined to sign acknowledgement

_____

Staff Signature: _____ Date: _____

Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.

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Office Financial Policy

Payment is due at the time of service. We accept most insurances, cash, check, Denefits (no credit check with 6 or 12 month payment options), Visa, Mastercard, Discover, and American Express. Occasionally, in-office payment plans will be offered for major procedures if the office deems appropriate. We also have an in-office discount membership plan, which offers up to 25% off services.

Office Cancellation Policy

We understand that unexpected emergencies and changes in schedule can arise, but we ask that if you need to cancel an appointment, please make your best effort to give our office 48 hours notice. Failure to do so could result in a cancellation fee.

I understand and agree to to the above financial and cancellation policies.

Name _____

Signature _____ *Date* _____

Prior to appointment, send completed packet to:

Email:
Batavia@mooreheaddentistry.com

Fax:
513-732-0552

Mailing Address:
Moorehead Family Dentistry
285 E. Main Street Suite 6
Batavia, OH 45103