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:

Health History Form

Patient First Name:	Last Name:	DOB:	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	☐
Congential 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
Do your gums bleed when you brush or floss?	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐
Does food or floss catch between your teeth?	☐
Is your mouth dry?	☐
Have you had any periodontal (gum) treatments?	☐
Have you ever had orthodontic (braces) treatment?	☐
Have you had any problems associated with previous dental treatment?	☐
Are you currently experiencing dental pain or discomfort?	☐
Do you have earaches or neck pain?	☐
Do you have any clicking, popping or discomfort in the jaw?	☐
Do you brux or grind your teeth?	☐
Do you have sores or ulcers in your mouth?	☐
Do you wear dentures or partials?	☐
Have you ever had a serious injury to your head or mouth?	☐
Do you have difficulty chewing, swallowing, or moving the jaw and tongue?	☐
Have you been told that you snore?	☐
Is there a history of heart disease in your immediate family?	☐
Do you have a family history of diabetes?	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

If time or money were not a barrier, is there anything you'd change about your smile?

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:
Diane@mooreheaddentistry.com

Fax:
513-984-3818

Mailing Address:
Moorehead Family Dentistry
10427 Kenwood Road
Cincinnati, OH 45242

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(Only fill out this information if you would like us to request xrays and/or records from a previous dentist office.)

Records Release Form

I give _______________________________ (previous dentist office) my permission to release any and all of my records on file to Moorehead Family Dentistry. This authorization is for myself and any of my minor children.

Printed Name _____________________________ (DOB) _____________

Signed ___________________________________ Date _______________

Name of minor children (if applicable)

__________________________________ (DOB)____________

__________________________________ (DOB)____________

__________________________________ (DOB)____________

Records can be sent to:

Address:
Moorehead Family Dentistry
10427 Kenwood Rd.
Blue Ash, OH 45242

Email:
diane@mooreheaddentistry.com

Fax:
(513) 984-3818