



MOOREHEAD

FAMILY DENTISTRY

Patient Registration

Patient Name:		Preferred Name:		Date:	
Home Address:		City:		State:	Zip:
<input type="checkbox"/> Home address and home phone # are same for entire family					
Cell Phone #:		Home Phone #:		Work Phone #:	
Social Security #:		DOB:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child					
<i>If the subscriber is not the patient, please fill out the subscriber info below.</i>					
Subscriber's Full Name:			Preferred Name:		
<small>first last middle initial</small>					
Subscriber's Address:					
<small>street city state zip</small>					
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 responsible for account is different than patient or subscriber above, please fill out this section.

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



Health History Form

Patient Name:	Phone:
Primary Care & Specialty Physician(s): [cardiologist, OB/GYN, 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) <input type="checkbox"/>		Seizures/Epilepsy <input type="checkbox"/>		COPD <input type="checkbox"/>		Thyroid Disorders <input type="checkbox"/>	
Heart Failure (weak heart) <input type="checkbox"/>		Depression or Panic Attacks <input type="checkbox"/>		Emphysema <input type="checkbox"/>		Diabetes Mellitus <input type="checkbox"/>	
High Blood Pressure <input type="checkbox"/>		Psychosis or Mania <input type="checkbox"/>		Chronic Bronchitis <input type="checkbox"/>		Immune Disorder <input type="checkbox"/>	
Low Blood Pressure <input type="checkbox"/>		Multiple Sclerosis <input type="checkbox"/>		Asthma <input type="checkbox"/>		Pregnant (due date: _____) <input type="checkbox"/>	
Arrhythmias (irregular beat) <input type="checkbox"/>		Headaches/Migraine <input type="checkbox"/>		Sinus/Hay Fever <input type="checkbox"/>		Breast Feeding <input type="checkbox"/>	
Congenital Heart Defect <input type="checkbox"/>		Substance Abuse <input type="checkbox"/>		Obstructive Sleep <input type="checkbox"/>			
Valve Disease or Murmur <input type="checkbox"/>		Alzheimer's/other Dementia <input type="checkbox"/>				Excretory	
Artificial Heart Valve <input type="checkbox"/>		Physical/Mental Impairment <input type="checkbox"/>		Miscellaneous		Liver Disorder (noninfectious) <input type="checkbox"/>	
Endocarditis (Heart Infection) <input type="checkbox"/>		Infections		Cancer <input type="checkbox"/>		Kidney Disorder <input type="checkbox"/>	
Stroke or TIA <input type="checkbox"/>		Hepatitis <input type="checkbox"/>		Joint Replacements <input type="checkbox"/>		Bladder Disorder <input type="checkbox"/>	
Bleeding Problems <input type="checkbox"/>		HIV/AIDS <input type="checkbox"/>		Organ Transplant <input type="checkbox"/>		Ulcers or GERD <input type="checkbox"/>	
Blood Cell Disorders <input type="checkbox"/>		Tuberculosis <input type="checkbox"/>		Glaucoma <input type="checkbox"/>		Intestinal Problems <input type="checkbox"/>	

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?	<input type="checkbox"/>	Have you ever been told that you snore or have sleep apnea?	<input type="checkbox"/>
Have you ever had gum problems or gum surgery?	<input type="checkbox"/>	Have you ever lost any teeth?	<input type="checkbox"/>
Do you have any clicking, popping, or discomfort in your jaw?	<input type="checkbox"/>	Have you replaced the missing teeth with anything?	<input type="checkbox"/>

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 dependants.

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 health 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