MOOREHEAD
FAMILY DENTISTRY

# Patient Registration

Patient's Full Name: Date:

Home Address:
street city state zip

Home Phone Number: Cell Phone Number:

Social Security #: DOB: Relationship Status ◯ *Married* ◯ *Divorced* ◯ *Single*

Place of Employment:

Work Address:
street city state zip

Work Phone: Email Address:

Who may we thank for referring you to us?

Emergency Contact Name: Phone Number:

Best way to reach you during daytime hours: ◯ *Cell Phone* ◯ *Home Phone* ◯ *Work Phone*

## Additional Information

*Fill out this section only if person responsible for this account is different than above.*

Full Name:

Home Address:
street city state zip

Home Phone Number: Cell Phone Number:

Email Address: Social Security #:

Place of Employment:

Work Address:
street city state zip

Work Phone:

## Insurance Information

*Is the patient covered under dental insurance? If yes, please answer the following, if different than above.*

Insured's Name: Relationship to Patient:

Insured's Address:
street city state zip

Date of Birth: Social Security #: Insured ID #:

Insured's Place of Employment:

Insurance Carrier: Group Number:

*Is there a second insurance carrier? If yes, complete the following:*

Insured's Name: Relationship to Patient:

Insured's Address:
street city state zip

Date of Birth: Social Security #: Insured ID #:

Insured's Place of Employment:

Insurance Carrier: Group Number:

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# Health History Form

Patient Name: Date: 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 |
|---|---|
| **Cardiovascular** | |
| CAD (angina, heart attack) | ☐ |
| Heart Failure (weak heart) | ☐ |
| High Blood Pressure | ☐ |
| Low Blood Pressure | ☐ |
| Arrhythmias (irregular beat) | ☐ |
| Congential Heart defect | ☐ |
| Valve Disease or Murmur | ☐ |
| Artificial Heart Valve | ☐ |
| Endocardiis (Heart Infection) | ☐ |
| Stroke or TIA | ☐ |
| Bleeding Problems | ☐ |
| Blood Cell Disorders | ☐ |

| | Yes |
|---|---|
| **Nervous System** | |
| Seizures/Epilepsy | ☐ |
| Depression or Panic Attacks | ☐ |
| Psychosis or Mania | ☐ |
| Multiple Sclerosis | ☐ |
| Headaches/Migraine | ☐ |
| Substance Abuse | ☐ |
| Alzheimer's/other Dementia | ☐ |
| Physical/Mental Impairment | ☐ |
| **Infections** | |
| Hepatitis | ☐ |
| HIV/AIDS | ☐ |
| Tuberculosis | ☐ |

| | Yes |
|---|---|
| **Respiratory** | |
| COPD | ☐ |
| Emphysema | ☐ |
| Chronic Bronchitis | ☐ |
| Asthma | ☐ |
| Sinus/Hay Fever | ☐ |
| Obstructive Sleep | ☐ |
| **Miscellaneous** | |
| Cancer | ☐ |
| Joint Replacements | ☐ |
| Organ Transplant | ☐ |
| Glaucoma | ☐ |

| | Yes |
|---|---|
| **Endocrine** | |
| Thyroid Disorders | ☐ |
| Diabetes Mellitus | ☐ |
| Immune Disorder | ☐ |
| Pregnant (due date: _____ ) | ☐ |
| Breast Feeding | ☐ |
| **Excretory** | |
| Liver Disorder (noninfectious) | ☐ |
| Kidney Disorder | ☐ |
| Bladder Disorder | ☐ |
| Ulcers or GERD | ☐ |
| Intestinal Problems | ☐ |

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

Have you ever recieved a local anesthetic? No A general anesthetic? No Any problems? No

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? | ☐ |
| Is your home water supply fluoridated? | ☐ |
| 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? | ☐ |

| | Yes |
|---|---|
| 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?

How do you feel about your smile?

**Patient Signature:**

_____

**For Office Use Only**

Summary Notes Following Interview:

Baseline Vital Signs: BP _____ HR _____ SpO2 _____

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## Insurance Release and Authorization

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

_____

*signed*

I also authorize payment directly to Dr. Charles D. Moorehead, for benefits otherwise payable to me, for myself and/or dependants.

_____

*signed*

## Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Charles D. Moorehead may use and disclose my protected health information. I understand that Charles D. Moorehead 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 of Parent/Guardian: _____

Date: _____

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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, CareCredit (which can provide 6 months no interest financing for those who qualify), 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" and have a "5% pay today courtesy."

## 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 the above office 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