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 responsible 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
Cardiovascular	
CAD (angina, heart attack)	☐
Heart Failure (weak heart)	☐
High Blood Pressure	☐
Low Blood Pressure	☐
Arrhythmias (irregular beat)	☐
Congenital Heart Defect	☐
Valve Disease or Murmur	☐
Artificial Heart Valve	☐
Endocarditis (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 A ☐ B ☐ C	☐
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 Type 1 ☐ Type 2	☐
Immune Disorder	☐
Excretory	
Liver Disorder (noninfectious)	☐
Kidney Disorder	☐
Bladder Disorder	☐
Ulcers or GERD	☐
Intestinal Problems	☐
Reproductive	
Known/chance of pregnancy	☐
Breast Feeding	☐

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: Are you allergic to Amoxicillin? Y / N Are you allergic to Clindamycin? Y / N

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 you gums bleed when you brush your teeth?	☐
Have you ever had gum problems or gum surgery?	☐
Do you have any clicking, popping, or discomfort in your jaw?	☐

	Yes
Have you ever been told that you snore or have sleep apnea?	☐
Have you ever lost any teeth?	☐
Have you replaced the missing teeth with anything?	☐

Do you currently smoke or have smoked in the past? Y / N If yes, how much do/did you smoke per day? Did you quit? Y / N If yes, when?

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?

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: _____

MOOREHEAD FAMILY DENTISTRY

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.

MOOREHEAD FAMILY DENTISTRY

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:
Blueash@mooreheaddentistry.com

Fax:
513-984-3818

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