PATIENT REGISTRATION

Today's Date_____

Patient's Name_____
Last *First* *M.I.*

Spouse/Parent Name_____

Address_____

City_____ State_____ Zip_____

Email Address _____

Telephone – Home_____ Cell_____ Work_____

Social Security #_____ Birth Date_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Long-Term Partner

Preferred Method of Phone Contact– *(Circle One)* Home Cell Work

Employer _____

Responsible Party

Name_____ Self / Parent / Spouse / Child / Other
Last *First* *M.I.* *Circle One*

Address (if different from above) _____

City_____ State_____ Zip_____

Telephone _____

Social Security #_____ Birth Date_____

Insurance Company Name _____ ID# _____

Referred by – (*Circle One)* Internet Website Neighborhood Insurance

Company, or Friend/Relative – Name _____

Purpose of Visit: _____

Name: _____ Date: _____

Last First Middle

DENTAL INFORMATION

Yes	No		Yes	No	
☐	☐	Do your gums bleed when you brush?	☐	☐	Do you have earaches or neck pains?
☐	☐	Have you ever had orthodontic treatment?	☐	☐	Have you had any periodontal treatments?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem with previous dental treatment? If yes, please explain:	☐	☐	Do you have soreness or pain in your jaw (TMJ)?
			☐	☐	Are you looking for cosmetic improvements?

MEDICAL INFORMATION

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Emphysema
☐	☐	AIDS or HIV Infection	☐	☐	Epilepsy
☐	☐	Anemia	☐	☐	Fainting Spells or Seizures
☐	☐	Arthritis	☐	☐	Gastrointestinal Disease
☐	☐	Rheumatoid Arthritis	☐	☐	G.E. Reflux/Persistent Heartburn
☐	☐	Asthma	☐	☐	Glaucoma
☐	☐	Blood Transfusion. If yes, date:	☐	☐	Hemophilia
☐	☐	Cancer/Chemotherapy/Radiation Treatment	☐	☐	Hepatitis, Jaundice or Liver Disease
Yes	**No**		☐	☐	Kidney Problems
☐	☐	**Cardiovascular Disease. If yes, please specify**	☐	☐	Mental Health Disorder - please specify
☐	☐	Angina	☐	☐	Malnutrition
☐	☐	Atherosclerosis	☐	☐	Night Sweats
☐	☐	Artificial heart valve	☐	☐	Neurological Disorder - please specify
☐	☐	*Requiring premedication?*	☐	☐	Osteoporosis
☐	☐	Congenital Heart Defects	☐	☐	Persistent Swollen Glands in Neck
☐	☐	Congestive Heart Failure	☐	☐	Respiratory Problems - please specify
☐	☐	Coronary Artery Disease	☐	☐	Severe Headaches/Migraines
☐	☐	Damaged Heart Valves	☐	☐	Severe or Rapid Weight Loss
☐	☐	Endocarditis	☐	☐	Sexually Transmitted Disease
☐	☐	Heart Attack	☐	☐	Sinus Trouble
☐	☐	Heart Murmur	☐	☐	Sleep Disorder
☐	☐	High Blood Pressure	☐	☐	Sores or Ulcers in mouth
☐	☐	***Is your blood pressure under control?***	☐	☐	Stroke
☐	☐	Low Blood Pressure	☐	☐	Systemic Lupus Erythematosus
☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Pacemaker	☐	☐	Thyroid Problems
☐	☐	Rheumatic Heart Disease/Rheumatic Fever	☐	☐	Ulcers
☐	☐	Chest pain upon exertion	☐	☐	Excessive Urination
Yes	**No**				
☐	☐	Chronic Pain	**Yes**	**No**	
☐	☐	Diabetes - please specify: Type I or Type II	☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:
☐	☐	Dry Mouth			
☐	☐	Eating Disorder - please specify			

Yes	No		Yes	No	
☐	☐	Has there been any change in your general health within the past year? If yes, explain:	☐	☐	Are you taking or have you ever taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?
☐	☐	Are you now under the care of a physician? If so, what condition(s) is being treated?	☐	☐	Do you use more than 2 pillows to sleep?
			☐	☐	Do you awaken from sleep feeling short of breath?
☐	☐	Have you had any serious illness, operation or been hospitalized in the past 5 years? If yes, explain:	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Antibiotic and dose?
☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, when was this operation done?	**Yes**	**No**	***WOMEN***
			☐	☐	Are you or could you be pregnant?
			☐	☐	Nursing?
			☐	☐	Taking birth control pills or hormonal replacement?
☐	☐	If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?	☐	☐	Are you aware that certain antibiotics may negate the action of birth control pills and lead to undesired fertility?

PLEASE COMPLETE OTHER SIDE OF FORM.

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

Yes	No		*If yes to response, please specify type of reaction*
☐	☐	Local Anesthetics	
☐	☐	Aspirin	
☐	☐	Penicillin or other antibiotics	
☐	☐	Barbiturates, sedatives or sleeping pills	
☐	☐	Sulfa drugs	
☐	☐	Codeine or other narcotics	
☐	☐	Latex	
☐	☐	Iodine	
☐	☐	Hay fever/seasonal	
☐	☐	Food (specify)	
☐	☐	Other (specify)	
☐	☐	Metal (specify)	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: *Prescription, over-the-counter medications (e.g. aspirin, antacids), dietary supplements and herbals (e.g. ginseng, ginkgo). Include medications taken as needed (e.g. nitroglycerin, vitamins, homeopathic remedies).*

Medication	Dose	Reason for taking

☐ Currently not taking any medications

To the best of my knowledge, all of the preceding answers are true and correct. I will notify Gene R. Patch, D.M.D., of any changes in health or medication at the next appointment without fail.

Patient's Signature (or responsible party) Name Date

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to the doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature (or responsible party) Relationship Date

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient's Signature (or responsible party) Name Date

PATIENT CONSENT FORM

Gene R. Patch, D.M.D.
10609 Old St. Augustine Road
Suite #3
Jacksonville, FL 32257

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your ***Notice of Privacy Practices,*** which contains a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____	_____
Print Patient Name	Relationship to Patient
_____	_____
Signature	Date

Gene R. Patch, DMD
Michael E. Patch, DDS
Cosmetic & General Dentistry

Take Our Smile Assessment!

Yes	No	
❑	❑	Are you comfortable showing your teeth when you smile?
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Are your gums or teeth sensitive?
❑	❑	Do you feel your teeth are too long?
❑	❑	Do you feel your teeth are too short?
❑	❑	Do you like the color of your teeth?
❑	❑	Are you missing teeth?
❑	❑	Are you interested in improving the appearance of your teeth?
❑	❑	Are you familiar with the benefits of dental implants?
❑	❑	Are your gums receding?
❑	❑	Are you anxious or fearful of treatment?
❑	❑	Are you happy with the alignment of your teeth?
❑	❑	Is fear holding you back from a perfect smile?
❑	❑	Is lack of time holding you back from a perfect smile?
❑	❑	Is cost holding you back from a perfect smile?
❑	❑	Is there something else holding you back from a perfect smile not listed?

Please feel free to explain any answers.

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