Alexiou Dental Arts

Patient Registration

Date _____

First Name _____ Last Name _____

Address _____

City, State, Zip Code _____

Home Phone _____ Cell Phone _____

Social Security # _____ Sex: ☐ Male ☐ Female Date of Birth _____

*Marital Status: ☐ Married ☐ Single ☐ Divorced ○ Separated ○ Widowed

***Who may we thank for referring you*?** _____

Person Responsible for Account (self, parent or guardian)

First Name _____ Last Name _____

Address _____

City, State, Zip Code _____

Phone # _____ Date of Birth _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Employer _____

Insured Social Security _____ Date of Birth _____

Dental Insurance Company_____

Group #_____ ID # _____

Secondary Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Employer _____

Insured Social Security _____ Date of Birth _____

Dental Insurance Company_____

Group #_____ ID # _____

Thank you for taking the time to provide us with your insurance information. This helps our office staff retain the correct insurance benefits so all claims can be processed correctly.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes	○ No	If yes:_____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes:_____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes:_____
Are you taking or have you taken any cortisone or steroids in the last two months?	○ Yes	○ No	If yes:_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ Yes	○ No	If yes:_____
Do you use tobacco?	○ Yes	○ No	If yes:_____

Women: Are you

○ Pregnant / Trying to get Pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics
○ Other: _____			

Do you have, or have you had, any of the following?

AIDS / HIV Positive	○ Yes	○ No	Epilepsy or Seizures	○ Yes	○ No	Lung Disease	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Excessive Bleeding	○ Yes	○ No	Mitral Valve Prolapse	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Fainting Spells / Dizziness	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Anemia	○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Pain in Jaw Joints	○ Yes	○ No
Angina (Chest Pain)	○ Yes	○ No	Heart Attack / Failure	○ Yes	○ No	Parathyroid Disease	○ Yes	○ No
Arthritis / Gout	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Psychiatric Care	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No	Radiation Treatments	○ Yes	○ No
Artificial Joint	○ Yes	○ No	Heart Trouble / Disease	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Asthma	○ Yes	○ No	Hemophilia	○ Yes	○ No	Rheumatism	○ Yes	○ No
Blood Disease	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Shingles	○ Yes	○ No
Breathing Problem	○ Yes	○ No	Herpes	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Bruise Easily	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
Cancer	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Stomach / Intestinal Disease	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Stroke	○ Yes	○ No
Cold Sores / Fever Blisters	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Tonsillitis	○ Yes	○ No
Convulsions	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Diabetes	○ Yes	○ No	Liver Disease	○ Yes	○ No	Tumors or Growths	○ Yes	○ No
Emphysema	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Ulcers	○ Yes	○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes:_____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ Date _____

(Signature of Patient, Parent, or Guardian)

LIST OF MEDICATIONS

Please provide us with a complete list of medications that you take on a routine basis.
This also includes over-the-counter medications and herbal remedies.

Allergies _____

Medication	Dose	How Often You Take the Medication	Reason/Condition
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
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18.			
19.			
20.			

Alexiou Dental Arts

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alexioudentalarts.com

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.
Those changes may apply to any of your protected heath information that we maintain.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed in our Privacy Practices. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

_____
Patient Name (Please Print)

_____
Patient Signature Date

-OR-

_____
Signature of Personal Representative Date

○ Parent ○ Guardian ○ Power of Attorney ◉ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement

Personal Health Information Disclosure Agreement

I, _____, authorize Alexiou Dental Arts to disclose my (self / child's) personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.)

_____
Name and Relationship (Please Print)

_____
Name and Relationship (Please Print)

_____
Name and Relationship (Please Print)

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)
_____