Patient Registration

Anthony Parisek, DDS, PLLC

Patient Information

Name: ____________________

Preferred Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Gender: ☐ Male ☐ Female

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

Date of Birth: ____________________

SS #: ____________________

Employer: ____________________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

E-mail Address (Required): ____________________

How did you find out about our office?: ____________________

Emergency Contact Name (Required): ____________________

Emergency Contact Relationship (Required): ____________________

Emergency Contact Phone (Required): ____________________

General Health Information:

#	Yes	No	Question
1.	☐	☐	Is your general health good?
2.	☐	☐	Has there been a change in your health within the last year?
3.	☐	☐	Have you been hospitalized in the last three years?
4.	☐	☐	Have you had a serious illness in the last three years? If Yes, please elaborate? ____________________
5.	☐	☐	Are you being treated by a physician now? If Yes, for what? ____________________ Date of last medical exam: ____________________
6.	☐	☐	Are you in pain now?

7. How important is your dental health to you?
☐ Not important ☐ Somewhat important ☐ Very important

Has a physician ever advised you that you have any of the following?

#	Yes	No	Condition
8.	☐	☐	Heart disease
9.	☐	☐	Heart attack
10.	☐	☐	Heart defects, Heart murmurs
11.	☐	☐	Rheumatic fever
12.	☐	☐	Stroke, hardening of arteries
13.	☐	☐	Aneurysm
14.	☐	☐	High blood pressure
15.	☐	☐	High cholesterol
16.	☐	☐	Asthma
17.	☐	☐	Tuberculosis or emphysema
18.	☐	☐	Other lung diseases
19.	☐	☐	Hepatitis, other liver disease
20.	☐	☐	Stomach problems, ulcers
21.	☐	☐	Acid reflux
22.	☐	☐	Arthritis
23.	☐	☐	Allergies to foods:____________
24.	☐	☐	Allergy to Penicillin
25.	☐	☐	Allergies to drugs:____________
26.	☐	☐	Allergy to latex
27.	☐	☐	Allergy to metals
28.	☐	☐	AIDS or HIV
29.	☐	☐	Tumors, cancer
30.	☐	☐	Artificial joint
31.	☐	☐	Back or neck injury
32.	☐	☐	Epilepsy
33.	☐	☐	Excessive bleeding
34.	☐	☐	Mental disorder:____________
35.	☐	☐	Rheumatism
36.	☐	☐	Eye diseases
37.	☐	☐	Glaucoma
38.	☐	☐	Skin diseases
39.	☐	☐	Lupus/SLE
40.	☐	☐	Anemia or blood disorder
41.	☐	☐	Veneral disease
42.	☐	☐	Syphilis or gonorrhea
43.	☐	☐	Herpes
44.	☐	☐	Kidney, bladder disease
45.	☐	☐	Thyroid, adrenal disease
46.	☐	☐	Diabetes
47.	☐	☐	Joint diseases
48.	☐	☐	Neurological condition
49.	☐	☐	Parkinson's Disease
50.	☐	☐	Crohn's Disease
51.	☐	☐	Family history of diabetes
52.	☐	☐	Family history of heart problems

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

#	Yes	No	Item
53.	☐	☐	Psychiatric care
54.	☐	☐	Radiation treatments
55.	☐	☐	Chemotherapy
56.	☐	☐	Prosthetic heart valve
57.	☐	☐	History of taking bisphosphonates
58.	☐	☐	Blood transfusions
59.	☐	☐	Bone marrow transplant
60.	☐	☐	Surgeries
61.	☐	☐	Pacemaker
62.	☐	☐	Contact lenses
63.	☐	☐	History of taking Redux (fen-phen)

Are you taking any of the following?

#	Yes	No	Item
64.	☐	☐	Recreational drugs
65.	☐	☐	Alcohol
66.	☐	☐	Chewing tobacco
67.	☐	☐	Cigarettes
68.	☐	☐	Other forms of tobacco (cigars, etc)
69.	☐	☐	Natural or herbal remedies
70.	☐	☐	Drugs, medications, over-the-counter medicines (inc. Aspirin)

Please list all drugs (Required): ____________________

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Women only

#	Yes	No	Question
71.	☐	☐	Are you or could you be pregnant/trying to get pregnant?
72.	☐	☐	Are you nursing?
73.	☐	☐	Are you taking any birth control pills, patches, or injections? Please list: ____________________

All patients

#	Yes	No	Question
74.	☐	☐	Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: ____________________

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Dental History

75. What is the primary reason for this dental appointment? ☐ Check-up ☐ Emergency ☐ Consultation ☐ Other: ______________________________

	Yes	No	
76.	☐	☐	Do you have a specific dental problem? Describe: ______________________________
77.	☐	☐	Do you think you have active decay or gum disease? Discuss: ______________________________
78.	☐	☐	Do you brush and floss on a routine basis? Discuss: ______________________________
79.	☐	☐	Do your gums ever bleed? Discuss: ______________________________
80.	☐	☐	Does food catch between your teeth?
81.	☐	☐	Do you have any loose teeth?
82.	☐	☐	Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind your teeth? Discuss: ______________________________
83.	☐	☐	Do you like your smile? Discuss ______________________________
84.	☐	☐	Would you like to have your teeth whitened?
85.	☐	☐	Have you considered braces or Invisalign treatment for your teeth?

86. If you could improve *anything* about your smile, what would it be? ______________________________

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Insurance-Related Authorizations Update (For patients with dental insurance only)

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.

Patient/Guardian Signature: ______________________________

Date: ______________________________

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Anthony Parisek, DDS, PLLC.

Patient/Guardian Signature: ______________________________

Date: ______________________________

Consent for Use and Disclosure of Health Information Update

Purpose of Consent: 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.

Notice of Privacy Practices: 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. A copy of our Notice is posted in our reception area.

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 health information that we maintain.

Patient/Guardian Signature: ______________________________ Date: ____________________

Certification

I have answered every question on this form accurately. I will verbally inform the doctor of all my health conditions and/or medications during my visit today and of any changes therein at each subsequent visits.

Patient/Guardian Signature: ______________________________ Date: ____________________

Thank you for taking the time to fill out your registration form!
We really appreciate it!