Moers Dental
COSMETIC & FAMILY DENTISTRY

2115 Lexington
Houston, TX 77098

T: (713) 524-8800
F: (713) 522-3496

# PATIENT REGISTRATION FORM

ID: _____ CHART ID: _____

FIRST NAME: _____ LAST NAME: _____ M.I. _____

PATIENT IS: ☐ POLICY HOLDER ☐ RESPONSIBLE PARTY

PREFERRED NAME: _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____ ADDRESS 2: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

◯ RESPONSIBLE PARTY IS ALSO POLICY HOLDER FOR PATIENT ◯ PRIMARY INSURANCE POLICY HOLDER

◯ SECONDARY INURANCE POLICY HOLDER

## PATIENT INFORMATION

ADDRESS: _____ ADDRESS 2: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

BIRTHDATE: _____ AGE: _____ SOC. SEC : _____ DRIVER LIC : _____

EMAIL: _____ ☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE VIA EMAIL

### SECTION 2

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED

MEDICAID ID: _____ PREF DENTIST: _____

EMPLOYER ID: _____ PREF PHARM: _____

CARRIER ID: _____ PREF HYG: _____

### SECTION 3

REFERRED BY: _____

PREVIOUS DENTIST: _____

EMER. CONTACT: _____

EMER. CONTACT #: _____

## PRIMARY INSURANCE INFORMATION

NAME OF INSURED: _____

RELATIONSHIP TO INSURED

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED SSN: _____ INSURED BIRTHDATE: _____

EMPLOYER: _____ INS. COMPANY: _____

ADDRESS: _____ ADDRESS: _____

ADDRESS 2: _____ ADDRESS 2: _____

CITY, STATE, ZIP: _____ CITY, STATE, ZIP: _____

REMAINING BENEFITS: $ _____ REMAINING DEDUCT.: $ _____

## SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____

RELATIONSHIP TO INSURED

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED SSN: _____ INSURED BIRTHDATE: _____

EMPLOYER: _____ INS. COMPANY: _____

ADDRESS: _____ ADDRESS: _____

ADDRESS 2: _____ ADDRESS 2: _____

CITY, STATE, ZIP: _____ CITY, STATE, ZIP: _____

REMAINING BENEFITS: $ _____ REMAINING DEDUCT.: $ _____

# MEDICAL HISTORY

PATIENT NAME: _____ BIRTHDATE: _____

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

| | | |
|---|---|---|
| ARE YOU UNDER A PHYSICIANS CARE NOW? | ☐ YES | ☐ NO |
| HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? | ☐ YES | ☐ NO |
| HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? | ☐ YES | ☐ NO |
| ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? | ☐ YES | ☐ NO |
| DO YOU TAKE, OR HAVE YOU TAKEN PHEN-FEN OR REDUX? | ☐ YES | ☐ NO |
| HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY MEDICATION CONTAINING BISPHOSPHONATES? | ☐ YES | ☐ NO |
| ARE YOU ON ANY SPECIAL DIET? | ☐ YES | ☐ NO |
| DO YOU USE TOBACCO PRODUCTS? | ☐ YES | ☐ NO |
| DO YOU USE CONTROLLED SUBSTANCES? | ☐ YES | ☐ NO |

**WOMEN**

| | | |
|---|---|---|
| ARE YOU PREGNANT OR TRYING TO GET PREGNANT? | ☐ YES | ☐ NO |
| ARE YOU TAKING ANY ORAL CONTRACEPTIVES? | ☐ YES | ☐ NO |
| ARE YOU CURRENTLY NURSING? | ☐ YES | ☐ NO |

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE USE THE SPACE BELOW TO GIVE US ANY PERTINENT INFORMATION i.e. TYPE OF SURGERY, INJURY, ETC.

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ ASPIRIN ☐ PENICILLIN ☐ COEDINE ☐ LOCAL ANESTHETICS ☐ ACRYLIC ☐ METAL

☐ LATEX ☐ SULFA DRUGS ☐ OTHER PLEASE LIST: _____

DO YOU HAVE ANY OF THE FOLLOWING?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV POSITIVE | ☐ YES ☐ NO | BRUISE EASILY | ☐ YES ☐ NO | EPILEPSY OR SEIZURES | ☐ YES ☐ NO |
| ALZHEIMER'S DISEASE | ☐ YES ☐ NO | CANCER | ☐ YES ☐ NO | EXCESSIVE BLEEDING | ☐ YES ☐ NO |
| ANAPHYLAXIS | ☐ YES ☐ NO | CHEMOTHERAPY | ☐ YES ☐ NO | EXCESSIVE THIRST | ☐ YES ☐ NO |
| ANEMIA | ☐ YES ☐ NO | CHEST PAINS | ☐ YES ☐ NO | FAINTING SPELLS/DIZZINESS | ☐ YES ☐ NO |
| ANGINA | ☐ YES ☐ NO | COLD SORES/FEVER BLISTERS | ☐ YES ☐ NO | FREQUENT COUGH | ☐ YES ☐ NO |
| ARTHRITIS/GOUT | ☐ YES ☐ NO | CONGENITAL HEART DISORDER | ☐ YES ☐ NO | FREQUENT DIARRHEA | ☐ YES ☐ NO |
| ARTIFICIAL HEART VALVE | ☐ YES ☐ NO | CONVULSIONS | ☐ YES ☐ NO | FREQUENT HEADACHES | ☐ YES ☐ NO |
| ARTIFICIAL JOINT | ☐ YES ☐ NO | CORTISONE MEDICINE | ☐ YES ☐ NO | GENITAL HERPES | ☐ YES ☐ NO |
| ASTHMA | ☐ YES ☐ NO | DIABETES | ☐ YES ☐ NO | GLAUCOMA | ☐ YES ☐ NO |
| BLOOD DISEASE | ☐ YES ☐ NO | DRUG ADDICTION | ☐ YES ☐ NO | HAY FEVER | ☐ YES ☐ NO |
| BLOOD TRANSFUSION | ☐ YES ☐ NO | EASILY WINDED | ☐ YES ☐ NO | HEART ATTACK/FAILURE | ☐ YES ☐ NO |
| BREATHING PROBLEM | ☐ YES ☐ NO | EMPHYSEMA | ☐ YES ☐ NO | HEART MURMUR | ☐ YES ☐ NO |

## MEDICAL HISTORY, continued

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HEART PACEMAKER | ☐ YES ☐ NO | LOW BLOOD PRESSURE | ☐ YES ☐ NO | SHINGLES | ☐ YES ☐ NO |
| HEART TROUBLE/DISEASE | ☐ YES ☐ NO | LUNG DISEASE | ☐ YES ☐ NO | SICKLE CELL DISEASE | ☐ YES ☐ NO |
| HEMOPHILIA | ☐ YES ☐ NO | MITRAL VALVE PROLAPSE | ☐ YES ☐ NO | SINUS TROUBLE | ☐ YES ☐ NO |
| HEPATITIS A | ☐ YES ☐ NO | OSTEOPROSIS | ☐ YES ☐ NO | SPINA BIFIDA | ☐ YES ☐ NO |
| HEPATITIS B OR C | ☐ YES ☐ NO | PAIN IN JAW JOINTS | ☐ YES ☐ NO | STOMACH/INTESTINAL DISEASE | ☐ YES ☐ NO |
| HERPES | ☐ YES ☐ NO | PARATHYROID DISEASE | ☐ YES ☐ NO | STROKE | ☐ YES ☐ NO |
| HIGH BLOOD PRESSURE | ☐ YES ☐ NO | PSYCHIATRIC CARE | ☐ YES ☐ NO | SWELLING OF LIMBS | ☐ YES ☐ NO |
| HIGH CHOLESTROL | ☐ YES ☐ NO | RADIATION TREATMENTS | ☐ YES ☐ NO | THYROID DISEASE | ☐ YES ☐ NO |
| HIVES OR RASH | ☐ YES ☐ NO | RECENT WEIGHT LOSS | ☐ YES ☐ NO | TONSILITIS | ☐ YES ☐ NO |
| HYPOGLYCEMIA | ☐ YES ☐ NO | RENAL DIALYSIS | ☐ YES ☐ NO | TUBERCULOSIS | ☐ YES ☐ NO |
| IRREGULAR HEARTBEAT | ☐ YES ☐ NO | RHEUMATIC FEVER | ☐ YES ☐ NO | TUMORS OR GROWTHS | ☐ YES ☐ NO |
| KIDNEY PROBLEMS | ☐ YES ☐ NO | RHEUMATISM | ☐ YES ☐ NO | ULCERS | ☐ YES ☐ NO |
| LEUKEMIA | ☐ YES ☐ NO | SCARLET FEVER | ☐ YES ☐ NO | VENEREAL DISEASE | ☐ YES ☐ NO |
| LIVER DISEASE | ☐ YES ☐ NO | | | YELLOW JAUNDICE | ☐ YES ☐ NO |

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES ☐ NO PLEASE LIST: _____

ADDITIONAL 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.

SIGNATURE _____ DATE _____

PATIENT, PARENT OR GUARDIAN

Moers Dental
COSMETIC & FAMILY DENTISTRY

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Houston, TX 77098

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F: (713) 522-3496

# PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing th is form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

THIS CONSENT WAS SIGNED BY: _____ DATE _____

PRINTED NAME OF PATIENT: _____

RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT) _____

IN THE PRESENCE OF (PRACTICE REPRESENTATIVE) _____

**OFFICE USE ONLY**

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE _____ INTIALS _____ REASON _____