

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

**Section 3**

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00



PATIENT MEDICAL HISTORY(Copy)

Patient Name:

Birth Date:

Date Created:

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

- 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 any medications, pills, or drugs?  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
- Have you been told you require antibiotics prior to any dental procedures?  Yes  No

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

- Do you have any allergies not listed above?  Yes  No If yes
- Other?  If yes

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

- Blood Thinners  Radiation Treatments  Diabetes  Hepatitis A
- Anaphylaxis  Drug Addiction  Hepatitis B or C  Kidney Problems
- Herpes  Rheumatic Fever  High Blood Pressure  Epilepsy or Seizures
- Artificial Heart Valve  Excessive Bleeding  Artificial Joint  Asthma
- Fainting Spells/Dizziness  Irregular Heartbeat  Anemia, Hemophilia or Blood Disease  Kidney Problems
- Liver Disease  Stroke  Bruise Easily  Cancer
- Lung Disease  Thyroid Disease  Chemotherapy  Mitral Valve Prolapse
- Heart Attack/Failure  Osteoporosis  Tuberculosis  Heart Murmur
- Pain in Jaw Joints  Congenital Heart Disorder  Heart Pacemaker  Heart Trouble/Disease
- Psychiatric Care  HIV Positive/AIDS

- Have you ever had any serious illness not listed  Yes  No If yes

Comments:

[Empty text box for 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.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Signature of Patient, Parent or Guardian:

X

Date:



# ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Scott E Watson DMD  
572 Titus Avenue  
Rochester, NY 14617

## Acknowledgement

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of Scott E Watson DMD's *HIPAA Notice of Privacy Practices*.

I understand that Scott E Watson DMD's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Scott E Watson DMD's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Scott E Watson DMD's *HIPAA Notice of Privacy Practices*, I may contact Scott E Watson DMD at (585) 342-4220.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Scott E Watson DMD will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Scott E Watson DMD's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Scott E Watson DMD, noted above, for assistance.

Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

## FOR OFFICE USE ONLY

Scott E Watson DMD made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Scott E Watson DMD was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on \_\_\_\_\_, 20\_\_\_\_\_.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): \_\_\_\_\_

Date Received	By	Patient ID