MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Commerce Dental Group

Acknowledgement Of Receipt Of Notice Of Privacy Practices

** You May Refuse to Sign This Acknowledgement **

I, _____, have received a copy of this office's Notice of Privacy Practices. A copy of this "Acknowledgement" is available upon request.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

_____

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) _____

I hereby authorize payment directly to Commerce Dental Group of the dental benefits otherwise payable to me.

This authorization is valid until authorization is revoked.

_____ _____

Patient or Authorized Person's Signature Date

You, Commerce Dental Group, are authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefit.

This authorization is valid until authorization is revoked.

I know that I have a right to receive a copy of this authorization on request and agree that a photographic copy of this authorization is as valid as the original.

_____ _____

Patient or Authorized Person's Signature Date

Welcome!

REGISTRATION FORM

Section I: Patient Information **Date**_____

First Name:_____ Last Name:_____ Middle Initial:____
Name you wish to be called:_____
Address:_____ City:_____ State:_____ Zip_____
Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____
The best time to contact me is:_____ ☐ **A.M.** ☐ **P.M. on my** ☐ **Home phone** ☐ **Work phone** ☐ **Cell phone**
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer:_____
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency:_____ Phone:_____
Email Address:_____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III **Insurance Information**

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____ City_____ State:_____ Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____ City_____ State:_____ Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____