



## New Patient Registration Form—Welcome to Our Practice!

Patient Name: \_\_\_\_\_  
*Last First MI*

Preferred Name: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_  Child  Other

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Address: \_\_\_\_\_  
*City State Zip*

Whom may we thank for referring you to our practice? \_\_\_\_\_

In Case of Emergency, who should be notified: \_\_\_\_\_  
*Name Phone*

### Primary Dental Insurance:

Name of Subscriber: \_\_\_\_\_  
*Last First MI*

Subscriber's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Relationship to Subscriber:  Self  Spouse  Child  Other

Subscriber's Address \_\_\_\_\_  
*(If different from Patient) City State Zip*

Ins. Plan Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

***\*If you have a Secondary Dental Insurance, please give us your card/info***

### Insurance Authorization:

- By Checking this box I: authorize my insurance to pay my benefits directly to the dentist for all services rendered  
authorize the use of electronic signature on all insurance submissions  
authorize the dentist to release all information necessary to secure the payment of benefits  
understand that I am financially responsible for all charges, whether or not paid by insurance

### Dental Information:

How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

Are your teeth sensitive?  Yes  No If yes, describe: \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Do your gums bleed when you brush or floss?  Yes  No

Have you had periodontal (gum) treatments?  Yes  No Have you had orthodontic treatment?  Yes  No

Do you use any other dental cleaning aids? (electric toothbrush, waterpik, water flosser, soft picks)?  Yes  No  
*List:* \_\_\_\_\_

Name of previous Dentist: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Date of most recent x-rays: \_\_\_\_\_

**Physician Information:**

Name of Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of most recent physical exam: \_\_\_\_\_

**Medical History:** Indicate which of the following you have had or presently have. Checking the box will indicate a “YES” response, leaving blank will indicate a “NO” response.

<input type="checkbox"/> Allergies-Seasonal	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Persistent Heartburn
<input type="checkbox"/> Allergy-Latex	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pre-diabetic
<input type="checkbox"/> Allergy-Penicillin	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Allergy-Sulfa	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Allergy-Other	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Other _____	_____	_____	_____

- Have you ever been hospitalized?  Taking dietary supplements  Subject to frequent headaches?
- Taking medication for weight control (ie: fen-phen?)  Use tobacco products (smoking, chew, e-cigarette/vape)
- Presently being treated for any other illness? **FEMALE ONLY:**  Pregnant  Taking birth control pills

**Do you take PREMEDICATION for your dental visits?** If yes, please explain: \_\_\_\_\_

List any medications, supplements, or vitamins you are taking (or give us a paper copy of your meds list):  
\_\_\_\_\_  
\_\_\_\_\_

Describe any medical treatment, impending surgery, or other treatment that may affect your dental treatment:  
\_\_\_\_\_

By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

\_\_\_\_\_  
*Signature* *Date*

Stoughton Family Dental  
HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** name of Patient or  
Guardian of Patient

\_\_\_\_\_  
Please **sign** for Patient

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

**PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:**

(This includes spouses, stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

**Privacy Officer Name and Contact Number: Marcie Rauls- Practice Manager - 608-873-6271 Email: marcie@lifetimemilesmiles.com**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment \_\_\_\_\_

I could not communicate with the patient \_\_\_\_\_

The patient refused to sign \_\_\_\_\_

The patient was unable to sign because \_\_\_\_\_

Other (please describe) \_\_\_\_\_

Signature of Privacy Officer \_\_\_\_\_



## X-Ray/Records Release Form

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Please complete and email/mail to your previous dental provider if you would like any records or x-rays transferred to our office.

Date: \_\_\_\_\_

Please send all current records, including bitewing x-rays taken within the last 24 months, full series or panoramic x-ray taken within the last 5 years, and any other pertinent dental records to:

Stoughton Family Dental  
101 W. Main Street  
Stoughton, WI 53589  
info@stoughtondental.com  
608-873-6271

I/we have an appointment scheduled on: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Other family members

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Signature