LARRY E. TRAGESSER, D.D.S
9000 Kingston Pike
Knoxville, TN 37923
865-693-1047

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN

MAIDEN NAME	NAME YOU GO BY	MARITAL STATUS
		☐ S ☐ M ☐ D ☐ W

STREET ADDRESS	APT. NO.

CITY	STATE	ZIP	HOME PHONE

SOCIAL SECURITY NUMBER	AGE	GENDER	CELL PHONE
		☐ Male ☐ Female	

EMPLOYER	OCCUPATION	WORK PHONE

EMERGENCY CONTACT (NOT LIVING WITH YOU) / RELATION TO PATIENT	EMERGENCY CONTACT PHONE

SPOUSE OR PARENT / RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			☐ Parent ☐ Legal guardian ☐ Other _____

STREET ADDRESS	APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE

SOCIAL SECURITY NO.	DATE OF BIRTH

RESPONSIBLE PARTY EMPLOYER	OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.

SECOND PARENT INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			☐ Parent ☐ Legal guardian ☐ Other _____

STREET ADDRESS	APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE

SOCIAL SECURITY NO.	DATE OF BIRTH

RESPONSIBLE PARTY EMPLOYER	OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY	COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

SECONDARY

INSURANCE COMPANY	COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

HOW DID YOU HEAR ABOUT US?

☐ Friend or relative _____
☐ Referred by another physician/ Dr. _____
☐ Insurance provider list
☐ Other _____

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to Larry Tragesser, DDS and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release or any information requested by my insurance company.

Authorized signature _____ ***Date*** _____

Welcome Patient's Name_____

It is not our responsibility to determine if you require **Pre-Med** before your appointment; due to pre-existing medical condition (knee replacement, Mitral valve prolapse, etc.) We can call in a prescription of antibiotics if your primary physician requires.

1. Primary care physician's name?_____ Phone No._____
2. When was your last physical exam?_____
3. Are you taking and medications? (please list on back) YES NO
4. Do you routinely take health related substances? YES NO
5. Are you allergic to any medications? (please list on back) YES NO
6. Are you sensitive to metals or latex? YES NO
7. Are you pregnant or suspect you may be? YES NO
8. Do you take birth control medication? YES NO
9. Have you ever been treated for heart disease? YES NO
10. Do you have a pacemaker, artificial heart valve implant, or been diagnosed with mitral valve prolapse? YES NO
11. Have you ever had Rheumatic fever? YES NO
12. Do you have HIGH or LOW blood pressure? Please circle
13. Have you ever had a serious illness or major surgery? YES NO
14. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? YES NO
15. Have you ever taken medication for bone tumors/excessive calcium in your blood? YES NO
16. Do you have inflammatory diseases such as: arthritis or rheumatism YES NO
17. Do you have artificial joints/prosthesis? YES NO
18. Do you have any blood disorders? YES NO
19. Do you have any stomach problems? YES NO
20. Do you have any kidney problems? YES NO
21. Do you have any liver problems? YES NO
22. Are you Diabetic? YES NO
23. Do you have asthma? YES NO
24. Do you have epilepsy or seizure disorders? YES NO
25. Have you tested HIV positive? YES NO
26. Do you have AIDS? YES NO
27. Have you had or do you test positive for hepatitis? YES NO
28. Do you or have you had T.B. ? YES NO
29. Do you smoke, chew, or consume any form of Tobacco? YES NO
30. Do you regularly consume more than 1-2 alcoholic beverages per day? YES NO
31. Have you ever received psychiatric treatment? YES NO
32. Is there anything else we should know about your health ? YES NO

I certify that the above information is complete and accurate:

Patient signature_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/ USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPPA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form, If terms of our Notice change, a vised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of patient or Legal Representative Date

_____ _____

Printed Name of Patient Legal Relationship to the Patient

Consent to email or text for the appointment reminds and other healthcare communication.

If you approve, we may contact you via email and /or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke the consent at any time,

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please Initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please Initial _____.

OR

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.