Patient Registration

1

Personal Information

Name:

Parent's Name (if child):

Birthdate:

Social Security Number:

Place of Employment:

Address:

City: State: Zip:

Home Phone:

Cell Phone:

E-mail:

2

Dental Benefit (Insurance)

Insurance Company:

Group #:

Insured's information (if different than at left)

Name:

SSN:

Birthdate:

3

Dental History

Do you have a specific dental problem? Yes No
If so, please explain:

Is there anything you would like to change about your smile? If so, please explain: Yes No

Do you feel nervous about having dental treatment? Yes No

Are your teeth sensitive to hot, cold, sweets, pressure? (Please circle which) Yes No

Please rank the following in order in which they would keep you from receiving dental care:

____ Fear of pain ____ Cost of treatment

____ Lack of concern ____ Missing work time

4

Important Contacts

In case of emergency, please contact:

Relation:

Home Phone:

Work Phone:

Address:

City: State: Zip:

Who referred you to our office/how did you find us?

Consent for Treatment

The undersigned hereby authorizes Dr. Saimon Ramos and his staff to take X-rays, study models, scans, photographs or any other diagnostic aids deemed appropriate by Dr. Ramos, to make a thorough diagnosis. I also authorize Dr. Ramos to perform any and all forms of treatment, medication and therapy that may be indicated. I further authorize and consent that Dr. Ramos choose and employ assistance, as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility of payment for services provided for myself or my dependents, is mine. I understand that payment is due and payable at the time services are rendered, unless financial arrangements have been made. I also assign all insurance benefits to Dr. Ramos. Any payments received from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Patient Signature (Parent if Child) _____ Date _____ Witness _____

Health History

Name: _____ Date: _____

Sex M F Height _____ Weight _____ Single _____ Married _____

Do you have any current health problems?……..……Yes No
Have you been hospitalized in the past 5 years?……...Yes No
Are you currently under the care of a physician?……..……Yes No

Physician's Name: _____ Phone #_____

Address _____

Please explain any 'yes' answers from left:

For the following 31 questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Do you have or have you had any of the following diseases or problems?

1. Damaged heart valves, including heart murmur, mitral valve prolapse or rheumatic heart disease? …….Yes No
2. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency coronary occlusion, high or low blood pressure, arteriosclerosis, stroke) …… Yes No
   a. Do you have chest pains upon exertion?…….. Yes No
   b. Are you ever short of breath after mild exercise or when lying down?……Yes No
   c. Do your ankles swell?…….…….. Yes No
   d. Do you have inborn heart defects?……Yes No
   e. Do you have a cardiac pacemaker?…….…..Yes No
3. Allergy…….…….. Yes No
4. Sinus trouble…….. Yes No
5. Asthma or Hay Fever…….…… Yes No
6. Fainting spells or seizures……..Yes No
7. Epilepsy or other neurological disease…….. Yes No
8. Persistent diarrhea or recent weight loss……Yes No
9. Diabetes……..Yes No
10. Hepatitis, jaundice, or liver disease…….…….. Yes No
11. AIDS or HIV infection…….…. Yes No
12. Thyroid problems…….……..Yes No
13. Respiratory problems, emphysema, bronchitis, etc…… Yes No
14. Arthritis or painful, swollen joints…… Yes No
15. Joint replacement surgery…….. Yes No
16. Have you taken any medicine for osteoporosis in the past 10 years?.....Yes No
17. Stomach ulcer or hyperacidity……... Yes No
18. Kidney Trouble…….. Yes No
19. Tuberculosis……...Yes No
20. Persistent cough or cough that produces blood……..Yes No
21. Persistent swollen glands in neck…..…… Yes No
22. Sexually transmitted disease……..Yes No
23. Problems with mental health…… Yes No
24. Cancer..…….. Yes No
25. Treatment for a tumor or growth…….…….. Yes No
26. Problems of immune system……Yes No
27. Abnormal bleeding…….Yes No
28. Any blood disorder such as anemia……... Yes No
29. Drug dependency……... Yes No
30. Do you use tobacco……Yes No
31. Women:
    a. Are you pregnant?……Yes No
    b. Are you nursing?…….…… Yes No
    c. Are you taking birth control pills?…… Yes No

Are you allergic or have you had a reaction to any of the following medications or materials: Yes (circle which) No

Aspirin	Penicillin	Local Anesthetic
Codeine	Erythromycin	Novocaine
Vicodin	Tetracycline	Xylocaine
Sulfa drugs	Latex	Acrylic

Are you allergic to any other medications? Yes No
If so, what?_____

Please list all medications drugs and pills (including non-prescription) which you are now taking or have taken in the past two years:

Do you have any disease, condition, or problem not listed above that you think the doctor should know about? Yes No
If so, please explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctor or any of his staff responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medications change, I will inform the doctor and his staff at the next appointment.

Patient Signature (Parent of child) _____ Date: _____

Reviewed by doctor:

Date:

Notes:

BOWTIE
DENTIST

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
6. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes.