DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient Name: ______________________ Date ____________

SS/HIC/Patient ID #: ______________________

Mailing Address: ______________________

E-mail: ______________________

Sex: M F Birthday: ______________ Age: ______

Status: Married Widowed Single Minor Divorced

Occupation & Employer: ______________________ Business/School Phone: (___) ________

PHONE NUMBERS

Home: (___) ________ Cell: (___) ________ Work: (___) ________ Ext ________

Spouse's Cell: (___) ________ Spouse's Work: (___) ________ Best time and place to reach you: ________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household).

Name: ______________________ Relationship: ______________

Home Phone: (___) ________ Cell Phone: (___) ________ Work Phone: (___) ________

DENTAL INSURANCE

Who is responsible for this Account?: ______________________ Relationship to Patient: ____________

Insurance Co.: ______________________ Group #: ______________

Is patient covered by additional insurance: Yes No

Subscriber's Name: ______________________

Birthday: ____________ SS #: ______________

Relationship to Patient: ______________________

Insurance Co.: ______________________ Group #: ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with ______________________ and assign directly to Dr. Ann Hashitate DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Ann Hashitate DDS may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative: ______________________

Print Name of Patient, Parent, Guardian, or Personal Representative: ______________________

Date: ____________ Relationship to Patient: ______________

DENTAL HISTORY

Reason for today's visit: ______________________

Former Dentist: ______________________ City/State: ______________

Date of last dental visit: ______________ Date of last X-rays: ______________

Check box to indicate if you have had any of the following:

- ❏ Bad Breath
- ❏ Bleeding gums
- ❏ Blisters on lips or mouth
- ❏ Burning sensation on tongue
- ❏ Chew on one side of mouth
- ❏ Cigarette, pipe, cigar smoking
- ❏ Clicking or popping jaw
- ❏ Dry mouth
- ❏ Fingernail biting
- ❏ Food collection between teeth
- ❏ Foreign objects
- ❏ Grinding teeth
- ❏ Gums swollen or tender
- ❏ Jaw pain or tiredness
- ❏ Lip or cheek biting
- ❏ Loose teeth or broken fillings
- ❏ Mouth breathing
- ❏ Mouth pain, brushing
- ❏ Orthodontic treatment
- ❏ Pain around ear
- ❏ Periodontal treatment
- ❏ Sensitivity to cold
- ❏ Sensitivity to heat
- ❏ Sensitivity to sweets
- ❏ Sensitivity when biting
- ❏ Sores/growths in your mouth
- ❏ Vaping

How often do you floss? ______________

How often do you brush? ______________

HEALTH HISTORY

Physician's Name: ______________________ Date of last visit: ________

Have you taken any of the drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). Circle: Yes No

Check box to indicate if you have any of the following:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally, with extractions or surgery
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis Type ___
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Sleep Apnea
- ❑ Special Diet
- ❑ Stroke
- ❑ Swollen Feet of Ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Weight loss, unexplained
- ❑ Do you wear contact lenses?

Women:

Are you pregnant? Yes No Due Date: ____________ Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and why you are taking them, and the correlating diagnosis:

____

Pharmacy Name: ______________ Phone: (___) _______

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other ____________

HIPAA NOTICE OF PRIVACY PRACTICES FOR KOKO HEAD DENTAL

❑ Check if you want a copy of HIPAA Notice of Privacy Practices

I have read and understood the HIPAA Notice of Privacy Practices.

Print Name: ______________________

Signature: ______________________ Date: ____________