Greenhaven Dental Care
930 Florin Rd. Ste 101
Sacramento, CA 95831

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLOWING CONFIDENTIAL INFORMATION

Date			
Patient Name			
Parents Name (if patient is a minor)			
Spouse			
Address			
City	State	Zip Code	
Home Phone Number			
Cell Phone Number			
Work Phone Number			
Email Address			
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security Number			
Emergency Contact	Name	Phone Number	
Closest relative not living with you	Name	Phone Number	

Dental Insurance Information ☐ Check here if we have your insurance information on file	
Insurance Company	Insurance Phone Number
Subscriber Full Name	Subscriber Birthdate
ID #	☐ Check here if insurance uses your Social Security #
Subscriber Employer	
Insurance Group Number	

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Is your general health good? YES NO

If NO, explain: _____

2. Has there been a change in your health within the last year? YES NO

If YES, explain: _____

3. Have you gone to the hospital or emergency room or had a serious illness in the last three years? YES NO

If YES, explain: _____

4. Have you been under the care of a medical doctor in the past two years? YES NO

If YES, explain: _____

Date of last medical exam? _____ Reason for exam: _____

5. Are you in pain now? YES NO

If YES, explain: _____

Primary Physician's Name: _____ Phone Number: _____

6. Are you aware of being allergic to of have you ever reacted adversely to any medication or substance? YES NO

If YES, please list: _____

Have you ever had an allergic reaction to latex gloves? YES NO

7. Do you need to be pre-medicated for dental treatment? YES NO

If YES, please explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

Chest pain (angina) ……YES NO	Fever ……YES NO	Coughing up blood ……YES NO
Blood in stools ……YES NO	Difficulty urinating ……YES NO	Dizziness ……YES NO
Frequent vomiting ……YES NO	Excessive thirst ……YES NO	Joint pain or stiffness ……YES NO
Fainting spells ……YES NO	Night sweats ……YES NO	Bleeding problems ……YES NO
Diarrhea or constipation ……YES NO	Ringing in ears ……YES NO	Blurred vision ……YES NO
Jaundice ……YES NO	Difficulty swallowing ……YES NO	Shortness of breath ……YES NO
Recent significant weight loss ……YES NO	Persistent cough ……YES NO	Blood in urine ……YES NO
Frequent urination ……YES NO	Headaches ……YES NO	Bruise easily ……YES NO
Dry mouth ……YES NO	Swollen ankles ……YES NO	Sinus problems ……YES NO

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Heart disease ……YES NO	Asthma ……YES NO	Stomach problems or ulcers ……YES NO
Hepatitis ……YES NO	AIDS/HIV ……YES NO	Arthritis, rheumatism ……YES NO
Heart defects ……YES NO	Psychiatric care ……YES NO	Anemia ……YES NO
Tumors or cancer ……YES NO	Family history of heart disease ……YES NO	High blood pressure ……YES NO
Sexual transmitted disease ……YES NO	Surgeries ……YES NO	Emphysema or other lung disease ……YES NO
Heart murmurs ……YES NO	Osteoporosis ……YES NO	Liver disease ……YES NO
Chemotherapy ……YES NO	Heart attack ……YES NO	Seizures ……YES NO
Herpes ……YES NO	Hospitalization ……YES NO	Kidney or bladder disease ……YES NO
Rheumatic fever ……YES NO	Thyroid disease ……YES NO	Eye disease ……YES NO
Radiation ……YES NO	Artificial joint ……YES NO	Stroke ……YES NO
Canker or cold sores ……YES NO	Diabetes ……YES NO	Transplants ……YES NO
Skin disease ……YES NO	Family history of diabetes ……YES NO	Cosmetic Surgery ……YES NO
Hardening of arteries ……YES NO	Tuberculosis ……YES NO	Eating disorders ……YES NO

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

Recreational Drugs ……YES NO	Tobacco in any form ……YES NO	Antibiotics ……YES NO
Over the counter Drugs ……YES NO	Alcohol ……YES NO	Supplements ……YES NO
Weight loss medication ……YES NO	Bisphosphonate (Fosamax) ……YES NO	Aspirin ……YES NO

V. FOR WOMEN ONLY

Are you pregnant? YES NO If yes, what month? _____ Are you nursing? YES NO Are you taking birth control pills? YES NO

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dentist to contact my physician if necessary.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian Date Signature of Dentist Date

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____

Control#

PRESCRIPTION/OTC LIST

Patients Name: _____ Today's Date: _____

PRESCRIPTION MEDICATIONS I AM CURRENTLY TAKING:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

OVER THE COUNTER MEDICATIONS I AM CURRENTLY TAKING (INCLUDE VITAMINS, OILS, AND ANY HEALTH SUPPLEMENTS):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Consent Forms

Patient Name: _____ **DoB:** _____

INSURANCE BENEFITS:

Each insurance company offers several different insurance plans to their clients. Each of these insurance packages offer widely varying benefits, depending on the cost that the employer has available for that purpose. The "UCR" benefits you receive are based on a fee structure chosen by the insurance company for the package that your employer has selected. These fee schedules are not always a true reflection of what is a "usual and customary rate" in terms of our demographic area or the quality of dentistry we provide. Because of numerous plans and different fee schedules, we can only estimate your expected coverage. Keep in mind that insurance estimates are estimates only. Treatment fees are estimates and could be altered if your dental needs change. It will be our pleasure to assist you in maximizing your insurance benefits. Please advise us of any dental benefits used elsewhere. We will make every effort to discover the approximate amount your insurance will cover per procedure and bill your insurance company as a courtesy to you. Ultimately, however, you are responsible for all payment of treatment provided, regardless of any insurance involvement.

H.I.P.A.A. PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the rights to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such reactions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I acknowledge that I received from Greenhaven Dental Care a copy of the Dental Materials Fact Sheet dated May 2004.

CANCELLATION/NO SHOW POLICY

Greenhaven Dental Care requires a 24 business hour notice to cancel any appointments. The first cancellation made within the 24 business hour period will incur a charge of $25 and the second cancellation will incur a charge of $50.00 for basic services such as cleanings. If your appointment exceeds more than 60 minutes the cancellation/failed appointment fee will be $75 or higher depending on the amount of procedure time you are scheduled for.

_____ _____

Patient Signature Date