FOX CHAPEL FAMILY DENTAL

Patient Registration

(complete form must be filled to process insurance claim)

Patient Information

First Name: _____ Last Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Would you prefer a text message or email appointment reminder? ☐ Text ☐ Email

Social Security: _____ Birth Date: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Responsible Party/Insurance Policy Holder

(if someone other than patient)

First Name: _____ Last Name_____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security: _____ Birth Date: _____

☐ Resp. Party is Policy Holder ☐ Patient is Policy Holder ☐ Other _____

Insurance Information

Self purchased or provided by employer? ☐ Self ☐ Employer _____

Insurance Company: _____ Group #: _____

Address: _____ Policy #_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FOX CHAPEL FAMILY DENTAL

Patient Questionnaire

1) Are you happy with the shade of your teeth? Y N

Have you considered whitening? Y N

2) If you are unhappy with the size, shape and/or position of your teeth have you thought about veneers? Y N

3) Have you ever thought about straightening your teeth? Y N

If so, which of the following would interest you most?

- ☐ traditional
- ☐ tooth colored
- ☐ clear aligners (like Invisalign)

4) If you had braces in the past, do you still wear your retainer? Y N

5) If you have missing teeth or dentures, have you ever thought about dental implants? Y N

6) Do dental procedures make you nervous? Y N

If so, which following sedation options would interest you most?

- ☐ slight: Nitrous
- ☐ moderate: Oral Sedation
- ☐ significant: IV Sedation

Patient Questionnaire

Patient Name: _____ Date: ____/____/____

	YES	NO
1) Do you snore?	☐	☐
2) Is snoring a problem for you?	☐	☐
3) Does your significant other snore?	☐	☐
4) Is snoring a problem for your relationship?	☐	☐
5) Do you have High Blood Pressure?	☐	☐
6) Are you on Blood Pressure Medicine?	☐	☐
7) Do you have Heart Disease?	☐	☐
8) Have you had a Heart Attack?	☐	☐
9) Have you had a Stroke?	☐	☐
10) Are you on Blood Thinners?	☐	☐
11) Do you have Gastric Reflux (GERD)?	☐	☐
12) Do you have Type II Diabetes?	☐	☐
13) Are you more than 30 lbs overweight?	☐	☐
14) Are you having trouble losing weight?	☐	☐
15) Have you been told you stop breathing when asleep?	☐	☐
16) Do you wake up exhausted in the morning?	☐	☐

SCORE Your Survey Results:
If you answered YES to any question for items 1 to 4. You (#3 =your significant other) need a Sleep Test.
If you answered YES to 2 or more questions for items 5 to16. You need a Sleep Test.

17) Have you ever been given a CPAP/APAP device?	☐	☐
18) If so, do you use it every night?	☐	☐
19) Are you comfortable and satisfied with your CPAP/APAP?	☐	☐

SLEEP CERTIFIED™

Fox Chapel Family Dental
501 Freeport Road
Pittsburgh, PA 15215

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA): I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to tome and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date Signed: _____

Print Patient Name:_____

Sign Patient Name:_____

Relationship to Patient:_____