PATIENT REGISTRATION

First Name _____ Last Name _____

Preferred Name _____ How did you hear about us?: _____

Address _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Sex ☐ Male ☐ Female Marital Status _____

Birthdate _____ Age _____ Soc Sec # _____

Email Address _____

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Occupation/Job Title _____

Student Status

☐ Full Time ☐ Part Time

Responsible Party (if not the patient)

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Primary Dental Insurance

Name of Insured Person _____ Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID # _____ Employer _____

Birthdate _____ Insurance Company _____

Secondary Dental Insurance

Name of Insured Person _____ Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID # _____ Employer _____

Birthdate _____ Insurance Company _____

Medical History

Patient Name: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS DETAILED AND ACCURATELY AS POSSIBLE...

GENERAL QUESTIONS

Do you have a regular Physician? (name/phone #)	○ Yes ○ No	If yes	
Ever been hospitalized or had major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, drugs or vitamins?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes	
Ever taken Bisphosphonates such as Fosamax, Boniva or Actonel?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No	If yes	
Do you use any controlled substances?	○ Yes ○ No	If yes	

Are you ALLERGIC to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Any other ALLERGIES not listed above ? ○ Yes ○ No If yes _____

HEALTH CONDITIONS

PLEASE CHECK if you have(or have had), any of the following health conditions....

☐ Acid Reflux	☐ Congenital Heart Disorder	☐ Hepatitis A	☐ Radiation Treatments
☐ AIDS/HIV Positive	☐ Cortizone Medicine	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Alzhemier's Disease	☐ Diabetes	☐ Herpes	☐ Renal Dialysis
☐ Anaphylaxis	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Aneima	☐ Emphysema	☐ High Cholesterol	☐ Scarlet Fever
☐ Angina / Chest Pain	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Seasonal Allergies
☐ Arthritis / Gout	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Shingles
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Sinus Trouble
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Spina Bifida
☐ Auto Immune Disease	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Genital Herpes	☐ Low Blood Pressure	☐ Stroke/TIA
☐ Blood Transfusion	☐ Glaucoma	☐ Lung Disease	☐ Swelling of Limbs
☐ Breathing Problems	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Bruise Easily	☐ Heart Murmur	☐ Osteoporosis	☐ Tonsilitis
☐ Cancer or Tumors	☐ Heart Pacemaker	☐ Pain in Jaw Joints	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores/Fever Blister	☐ Hemophilia	☐ Psychiatric Care	☐ Venereal Disease

PERSONAL INFO:

Approximate height:_____

Approximate weight:_____

Emergency Contact Name, Relationship and Phone #:

_____

WOMEN: ARE YOU.....

☐ Pregnant (or trying to get pregnant)? ☐ Nursing? ☐ Taking Oral Contraceptives?

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 to the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ **Date:**_____

Signature of Patient, Parent or Guardian:

DENTAL HISTORY

When did you last see a Dentist:_____ Hygienist:_____

Have you had professional instruction in brushing and flossing? [ ]Yes [ ]No

Have you ever had any serious problems associated w/ dental treatment? [ ]Yes [ ]No

How often do you brush your teeth?:_____ How often do you floss?:_____

What type of toothbrush do you use?:_____ Do you use a mouth rinse? [ ]Yes [ ]No

Do your gums feel tender or swollen? [ ]Yes [ ]No

Do your gums bleed while brushing and/or flossing? [ ]Yes [ ]No

Do you avoid brushing any part of your mouth because of pain/sensitivity? [ ]Yes [ ]No

Do you feel twinges of pain when your teeth come in contact with hot / cold / sour? [ ]Yes [ ]No

Do you chew on only one side of your mouth? [ ]Yes [ ]No

Does food catch between your teeth? [ ]Yes [ ]No

Do you gag easily? [ ]Yes [ ]No

Do you clench or grind your teeth while sleeping or during the day? [ ]Yes [ ]No

Do you wear dentures (Full, Partial, Upper and/or Lower _____ [ ]Yes [ ]No

Do you wear an occlusal / night guard? [ ]Yes [ ]No

Are you apprehensive (nervous) about your dental treatment? [ ]Yes [ ]No

HAVE YOU HAD:

Clicking or noise in your jaw? [ ]Yes [ ]No

Ear aches? [ ]Yes [ ]No

Pain or headaches? [ ]Yes [ ]No

History of fingernail biting or gum chewing? [ ]Yes [ ]No

Braces? [ ]Yes [ ]No

Extractions? (wisdom teeth, etc.) [ ]Yes [ ]No

Accident or trauma to your head or neck? [ ]Yes [ ]No

General anesthesia? [ ]Yes [ ]No

Would you like a whiter / brighter smile? [ ]Yes [ ]No

SLEEP QUESTIONS:

Have you ever been diagnosed with sleep apnea? [ ]Yes [ ]No

Have you ever been told that you snore? [ ]Yes [ ]No

Do you get sleepy during the day? [ ]Yes [ ]No

Do you wake up feeling tired? [ ]Yes [ ]No

Do you currently sleep with a CPAP machine? [ ]Yes [ ]No

GENERAL CONSENT FOR DENTAL TREATMENT

Please read the following consent form carefully and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I hereby authorize and direct Dr. Gobran to perform **dental treatment** on me, which includes any necessary local anesthesia, radiographs or diagnostic aids such as photographs or dental models. I understand that none of the procedures listed below will be performed without first obtaining my verbal consent. I also understand that alternative methods of treatment, if any, along with their advantages and disadvantages will be explained to me.

In general terms, **dental treatment** authorized may include one or a number of the following:

Local Anesthetic
Cleaning of teeth and application of topical fluoride
Treatment of periodontal disease with deep cleaning
Application of sealants to the grooves of teeth
Treatment of diseased or injured teeth with composite filling material
Replacement of missing teeth with implants, bridges, partials or dentures
Extraction of one or more teeth
Treatment of diseased or injured oral tissues (hard and/or soft)
Treatment of mis-aligned teeth
The use of sedative medications to control apprehension and anxiety

I am advised that good results are expected in general, however the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding any treatment. I fully understand and authorize Dr. Gobran to perform any necessary treatment that is in her judgment as long as it is in my best interest and I have been advised of my financial obligation.

I understand that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection, which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they may include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination (the most common being the need for root canal therapy following routine restorative procedures). I understand that calculus removed on the teeth that has been present for a long period of time sometimes creates spaces between teeth that were not previously visible due to the presence of calculus.

I understand that insurance does not cover 100% of all services. Insurance is designed to give assistance, not full payment. Deductibles and copayments are my responsibility and are expected at the time of service. I further understand that it is my responsibility to inform the office of any changes in insurance coverage prior to services being rendered.

Account balances over 90 days are subject to an 18% interest charge and delinquent accounts are subject to submission to a collection agency, attorney or small claims court.

I understand that a notice of 2 working days is appreciated for any appointment changes and cancellations (or failure to show up) within 24 hours are subject to a service fee of $50.00 per scheduled hour.

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent. I also understand that this consent will remain in effect until such time I choose to terminate my relationship with the office and I have advised them of such termination.

_____ _____

Patient (or guardian) Signature Date

Monica Gobran, DMD
11 Harvard Street
Worcester, MA 01609

Notice of Privacy Practices Acknowledgment

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

- Conduct, plan and direct my 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 received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *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 healthcare 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 such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

Privacy Notice was given, Patient refused to sign Notice of Privacy Practices Acknowledgment:

Date: _____ Initials _____ Reason _____