DENTAL REGISTRATION AND HEALTH HISTORY

DATE_____

Patients Name_____How do you prefer to be addressed?_____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____

If Student, name of School / College: _____ City _____ State _____ PT Full

Whom may we thank for referring you to our office: _____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party _____ Relationship to Patient _____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Secondary Insurance Information

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? **Yes** **No**
   If yes, which family member (s)?_____
2. Date of last physical examination _____ Physician's Name _____
3. Date of last dental examination _____ Date of last dental x-rays _____
4. Previous Dentist's name _____City/State _____
5. Are you having pain or discomfort at this time? **Yes** **No**
6. Do you feel nervous about having dental treatment? **Yes** **No**
7. Have you ever had a bad experience in a dental office? **Yes** **No**
8. Is there anything you dislike about your smile? **Yes** **No**
9. Is there anything you would like to speak with the Doctor about in private? **Yes** **No**
10. Have you been a patient in the hospital during the past two years? **Yes** **No**
11. Have you been under the care of a medical doctor during the past two years? **Yes** **No**
12. Have you taken any medications or drugs in the past two years? **Yes** **No**
13. Are you taking any vitamins, herbal supplements or "cures"? **Yes** **No**
14. Have you ever had any excessive bleeding requiring special treatment? **Yes** **No**

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other: _____

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

Pharmacy :_____

Place a mark on yes or no to indicate if you have had any of the following:

Chest Pain	**Yes**	**No**	Shortness of Breath	**Yes**	**No**	Hives or skin rash	**Yes**	**No**
Heart Failure	**Yes**	**No**	Ulcers	**Yes**	**No**	Alcoholism	**Yes**	**No**
Heart Disease or Attack	**Yes**	**No**	Mental Retardation	**Yes**	**No**	Herpes	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Emphysema	**Yes**	**No**	Glaucoma	**Yes**	**No**
Heart Problems	**Yes**	**No**	Fainting or dizzy spells	**Yes**	**No**	*Steroid Treatment	**Yes**	**No**
Liver Disease	**Yes**	**No**	Eating Disorder	**Yes**	**No**	Arthritis	**Yes**	**No**
Heart Surgery	**Yes**	**No**	Epilepsy or seizures	**Yes**	**No**	*Any type of implant	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Persistent Cough	**Yes**	**No**	Dentures or Partials	**Yes**	**No**
*Heart Murmur	**Yes**	**No**	Tuberculosis (TB)	**Yes**	**No**	Birth defects	**Yes**	**No**
*Rheumatic Fever	**Yes**	**No**	Asthma	**Yes**	**No**	HIV Positive, ARC, AIDS	**Yes**	**No**
Psychiatric treatment	**Yes**	**No**	*Congenital Heart Problems	**Yes**	**No**	Hay fever	**Yes**	**No**
Sickle Cell Disease	**Yes**	**No**	Hepatitis A (Infectious)	**Yes**	**No**	Use of tobacco products	**Yes**	**No**
Sinus trouble	**Yes**	**No**	Hepatitis B (Serum)	**Yes**	**No**	Bruise easily	**Yes**	**No**
*Artificial joints	**Yes**	**No**	Hepatitis C or other	**Yes**	**No**	Jaundice	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	Heart pacemaker	**Yes**	**No**	Heart Surgery	**Yes**	**No**
Anemia	**Yes**	**No**	Stroke	**Yes**	**No**	Kidney Trouble	**Yes**	**No**
Blood transfusion	**Yes**	**No**	Drug addiction	**Yes**	**No**	Hemophilia	**Yes**	**No**
*Any type of transplant	**Yes**	**No**	Cold Sores	**Yes**	**No**	Diabetes	**Yes**	**No**
*Mitral Valve Prolapse	**Yes**	**No**	Radiation Therapy	**Yes**	**No**	Chemotherapy	**Yes**	**No**
						Cancer (type:)	**Yes**	**No**

***Antibiotic pre-medication may be required prior to your appointment.**

Have you ever experienced any of the following problems with your jaw:

Clicking	**Yes**	**No**
Pain in or around your ears ?	**Yes**	**No**
Difficulty opening or closing	**Yes**	**No**
Difficulty chewing	**Yes**	**No**
Do you have a history of trauma to your jaw?	**Yes**	**No**
Have you ever been diagnosed with TMJ/TMD?	**Yes**	**No**

Do you have currently have any problems listed below?
Please circle all that apply:

Swelling — Bad Taste
Bleeding Gums — Loose Teeth

Sensitive to:

Hot — Cold
Biting/Pressure — Sweets

Other: _____

Do you have any sores, lumps or growths in or near your mouth?	**Yes**	**No**
Have you ever had difficult extraction's in the past?	**Yes**	**No**
Have you ever had prolonged bleeding following extraction's?	**Yes**	**No**
Are there now any growths or sores in or around your mouth?	**Yes**	**No**
Do you habitually clench or grind your teeth during the day or night?	**Yes**	**No**

Problem with bad breath? (Halitosis)	**Yes**	**No**
Do you have any trouble chewing?	**Yes**	**No**
Does food collect between your teeth?	**Yes**	**No**
Have you ever had instructions in oral hygiene ?	**Yes**	**No**
Have you ever taken Redux or Pondimin (Fen Phen) ?	**Yes**	**No**

Have you ever been told you have gum problems?	**Yes**	**No**
Have you ever needed to see a periodontist ?	**Yes**	**No**
Do you now have bleeding gums or any other gum condition?	**Yes**	**No**
Is there anything related to your medical or dental history that you have not indicated above ?	**Yes**	**No**

If yes, please explain: _____

WOMEN: Are you pregnant now?	**Yes**	**No**	If yes, what is your due date? _____
Are you currently breast feeding?	**Yes**	**No**	
Are you taking oral contraceptives?	**Yes**	**No**	

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or guardian

Stone Creek Dental

Richard C. Axel D.D.S. P.A.
Tiffany M. Weyandt D.D.S.

ACKNOWLEDGEMENT OF RECEPIT OF NOTICE OF PRIVACY PRACTICES_

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(please print name)

(signature)

(date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

___ Individual refused to sign.
___ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.00 for each page, $8 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.