Patient Registration Form

WELCOME! We are pleased to have the opportunity to provide excellent service to you. Please take a few moments to complete this form. If you have any questions we'll be glad to help you.

Patient Information

Name: ______________________________________

Birthdate: ______________ SSN: ______________

Gender: __ Male __ Female

Address: ____________________________________

____

Email: ______________________________________

Home Phone: (_______)_____________

Work Phone: (_______)_____________

Cellphone: (_______)_______________

I prefer an appointment reminder via:

☐Text message ☐Email ☐Phone call

Do others in your family come here?

Name(s): ____________________________________

____

____

Emergency Contact

Name(s): ____________________________________

Telephone: ___________________________

Relationship:__________________________

How did you hear about us? ____________________

(If someone referred you, please write their name so we can thank them.)

Insurance Information

Primary	**Secondary**
Subscriber name: ____________________________	Subscriber name: ____________________________
DOB: ______________ SSN:__________________	DOB: ______________ SSN:__________________
Insurance: __________________________________	Insurance: __________________________________
Employer: ________________ Group#: ______________	Employer: ________________ Group#: ______________
Relationship to patient: _________________________	Relationship to patient: _________________________

I authorize the dentist or staff to take x-rays, diagnostic models, photographs, and other diagnostic aids deemed appropriate to make a diagnosis of my dental health needs. I authorize the dentist and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer reviews, educational purposes, billing of charges, legal and collection actions.

I authorize the dentist or staff to perform mutually agreeable treatments utilizing such assistance as the doctor deems necessary.

I agree to use the anesthetics or other medications as necessary for my treatment. I fully understand that using medications have certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. PAYMENT IS DUE AT THE TIME OF SERVICE.

I understand that repeated cancellations or missed appointments without giving Laurel Hills Dental a 24 hour notice, may result in a $50 charge and/or loss of future appointment privileges.

I have read and reviewed the office's NOTICE OF PRIVACY PRACTICE and STATE OF CALIFORNIA DENTAL MATERIALS FACT SHEET available on the Laurel Hills Dental website: www.SacDentist.com under the "Patient Center" tab and/or in the office.

Do you give Laurel Hills Dental permission to contact you on your cellphone to discuss account & insurance information?

☐**Yes** ☐**No**

____

PATIENT or GUARDIAN signature

____

Date

Medical History Form

Name: ____ **Date of Birth :** ______________

In order to provide greater safety to you and our staff in treating your dental needs, the information provided needs to be accurate and complete. If there is anything else that is unclear to you, please feel free to ask us. Thank you for choosing Laurel Hills Dental!

Prescription medicines you are currently taking: (Please provide us a copy of the list if it does not fit in this box.)	Allergies or reactions to medications or anesthetics:

1. Physician: ______________________ Facility (e.g. Kaiser, Sutter): ___________________ Contact #: ________________

2. Do you need to take prophylactic antibiotics before any dental treatment? ☐Yes ☐No
   If yes, what is the drug name: ________________________________

3. Have you had or do you currently have any of the following medical conditions? Please mark Yes or No.

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack / Surgery	☐	☐	Chronic cough	☐	☐	Bruise Easily
☐	☐	Chest Pain	☐	☐	Tuberculosis	☐	☐	Liver Disease
☐	☐	Congenital Heart Disease	☐	☐	Asthma	☐	☐	Jaundice
☐	☐	Heart Murmur	☐	☐	Radiation therapy	☐	☐	Neurological disorder
☐	☐	High Blood Pressure	☐	☐	Latex sensitivity/Allergy	☐	☐	Psychological care
☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems	☐	☐	Kidney Problems
☐	☐	Artificial Heart Valve	☐	☐	Chemotherapy	☐	☐	Stroke
☐	☐	Heart Pacemaker	☐	☐	Cancer. Type:__________	☐	☐	Artificial Joints
☐	☐	Rheumatic Fever	☐	☐	Hepatitis. Type: _________	☐	☐	Epilepsy/Seizures
☐	☐	Arthritis / Rheumatism	☐	☐	STD	☐	☐	Tumors
☐	☐	Fainitng/Dizziness	☐	☐	AIDS	☐	☐	Swollen Ankles
☐	☐	Diabetes. Type: ______	☐	☐	HIV positive	☐	☐	Osteoporosis/ Taking Bisphosonate drugs
☐	☐	Thyroid problems	☐	☐	Cold Sores	☐	☐	Taking weight loss meds (Fen-Phen & Redux)
☐	☐	Emphysema	☐	☐	Hemophilia			

4. Have you had or do you currently have any of the following dental conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Gum/Periodontal Treatment	☐	☐	Difficulty Sleeping/Snoring	☐	☐	Neck Pain / Headaches
☐	☐	Braces/Orthodontic Treatment	☐	☐	Clicking/Popping/Grinding of jaw	☐	☐	Difficulty in chewing
☐	☐	Trauma to head/teeth						
☐	☐	Oral Surgery						

6. For Women: Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No

Please use this space to cover anything else you want us to know.

I have answered all questions fully and to the best of my knowledge. If other health issues arise in the future, I understand that it is my responsibility to inform Dr. Hinh and the staff of these changes.

Patient Signature: ___________________ Guardian Signature (for patients below 18 y.o.): ___________________

Date: ________________