



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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address: _____ _____
Email: _____
Home Phone: (____) _____
Work Phone: (____) _____
Cellphone: (____) _____
I prefer an appointment reminder via: <input type="checkbox"/> Text message <input type="checkbox"/> Email <input type="checkbox"/> Phone call

Do others in your family come Name(s): _____ _____ _____
Emergency Contact Name(s): _____ Telephone: _____ Relationship: _____
How did you hear about us? _____ <small>(If someone referred you, please write their name so we can thank them.)</small>

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.

I consent to Laurel Hills Dental using my cell number to text me regarding my appointments and to call me regarding treatment, insurance or my account.

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	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack / Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes. Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy
<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitivity/Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Cancer. Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis. Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	STD
<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	HIV positive
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder
<input type="checkbox"/>	<input type="checkbox"/>	Psychological care
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/ Taking Bisphosonate drugs
<input type="checkbox"/>	<input type="checkbox"/>	Taking weight loss meds (Fen-Phen & Redux)

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

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Gum/Periodontal Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Braces/Orthodontic Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Trauma to head/teeth
<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping/Snoring
<input type="checkbox"/>	<input type="checkbox"/>	Clicking/Popping/Grinding of jaw

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain / Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing

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: _____