

So that we may provide you with the best possible care, please complete this entire form. PLEASE PRINT.

Date _____ Home Phone (_____) _____ Work Phone (_____) _____

Patient Name _____

Address _____

City _____ State _____ Zip _____ Social Security # _____ E-mail Address _____

Sex: Male Female Age _____ Birthday ____/____/____ Single Married Separated Divorced

Employed By _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. (_____) _____

Spouse Name _____ Birthday ____/____/____ Employed By _____

Business Address _____

City _____ State _____ Zip _____ Tel. (_____) _____ Social Security # _____

Who is responsible for this account? _____ Relationship to patient _____

Dental Insurance Primary Carrier

Insured's Name		Social Security #
Insurance Company		Ins. Co. Phone Number
Address		
City	State	Zip
Group Number	ID Number	Birthdate
Insured's Employer		

Dental Insurance Secondary Carrier

Insured's Name		Social Security #
Insurance Company		Ins. Co. Phone Number
Address		
City	State	Zip
Group Number	ID Number	Birthdate
Insured's Employer		

In case of an emergency, who should be notified? _____ Tel. (_____) _____

Who is your general dentist? _____ Tel. (_____) _____

Whom may we thank for referring you? _____

Pharmacy Name, Address and Phone _____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled.

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 payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable 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.

Signature of patient or parent of minor _____

Date _____

PATIENT REGISTRATION

SHADED AREAS FOR OFFICE USE ONLY

MEDICAL ALERTS (for office use only)

Blood Pressure _____

Patient Name _____ Date of Birth _____

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 N/A _____
- Have you ever been hospitalized or had a major operation? Yes No N/A _____
- Have you ever had a serious head or neck injury? Yes No N/A _____
- Are you taking any medications, pills, or drugs? Yes No N/A _____
- Have you taken Phen-Fen or Redux? Yes No N/A _____
- Are you on a special diet? Yes No N/A _____
- Do you pre-medicate for dental appointments? Yes No N/A _____
- Have you had heart valve replacement? Yes No N/A _____
- Do you use tobacco? Yes No N/A _____
- Do use controlled substances? Yes No N/A _____

WOMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

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

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Veneral Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any condition or illness not listed above? Yes No N/A _____

List current medications _____

List vitamins/herbs _____

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 care office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

SIGNATURE OF DOCTOR _____

MEDICAL HISTORY

DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Dr. Milita G. Borguet
110 North Essex Avenue
Narberth, PA 19072
Phone: 610-664-9510

NAME

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

(Please print)

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name:-

Relationship to individual: _____

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Hipa form