Patient Registration Form

Email: **Today's Date:**

Responsible Party: **Referred by:**

Name: **Home Phone** **Cell Phone**

Last First Middle ( ) ( )

Mailing Address:

City: **State:** **Zip:**

SS# : **Date Of Birth:** **Sex:** **M** **F**

Employer: **Business Phone** ( )

Emergency Contact: **Relationship** **Home Phone** ( ) **Cell Phone** ( )

College Student Status: ❑ Full Time ❑ Part Time

Employment: ❑ Full Time ❑ Part Time ❑ Retired

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Pref. Pharmacy: **Phone: ( )**

School Name:_____

Address:_____

Address 2:_____

City, State, Zip_____

Dental Insurance Information

Primary Insurance Information

Name of Insured:_____ **Relationship to Patient:** ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured SSN: _____ **Insured Birth Date:** _____

Employer:_____ **Insurance Company:** _____

Address:_____ **Address:** _____

Address 2: _____ **Address 2:** _____

City, State, Zip: _____ **City, State, Zip:** _____

ID#:_____ **Gr#**_____

Secondary Insurance Information

Name of Insured:_____ **Relationship to Patient:** ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured SSN: _____ **Insured Birth Date:** _____

Employer:_____ **Insurance Company:** _____

Address:_____ **Address:** _____

Address 2: _____ **Address 2:** _____

City, State, Zip: _____ **City, State, Zip:** _____

ID#:_____ **Gr#**_____

Dental Information

(For the following questions, mark X in response to the following questions.)

	Yes	No	DK
Do your gums bleed when you brush or Floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (Gum) treatments?	❑	❑	❑
Have you ever had orthodontic treatments? (braces)	❑	❑	❑
Have you had problems associated with previous dental treatment?	❑	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pain?	❑	❑	❑
Do you have any clicking, popping or jaw discomfort?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you use Tobacco?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of last dental exam:

What was done at that time?

Physician Name: **Phone: ( )**

MEDICAL CONDITIONS: Do you have (or have you had) any of the following diseases, problems, or symptoms?

YES NO DK **Eye/Ear/Nose/Throat problem**

If yes, please specify:

- ☐ Vision problems
  - ☐ Cataracts
  - ☐ Glaucoma
    - ☐ Narrow angle
    - ☐ Open angle
  - ☐ Macular degeneration
- ☐ Hearing impairment
- ☐ Hay fever/seasonal (allergic rhinitis)
- ☐ Other: _____

YES NO DK **Heart/Blood Pressure problem**

If yes, please specify:

- ☐ High blood pressure
- ☐ High cholesterol/high triglycerides
- ☐ Infective endocarditis
- ☐ Congenital heart defect/disease
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ Arrhythmia (irregular heart beat)
- ☐ Pacemaker/Implanted defibrillator
- ☐ Other: _____

YES NO DK **Breathing/Lung problem**

If yes, please specify:

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Obstructive sleep apnea
  - ☐ Use CPAP/BiPAP
  - ☐ Surgical correction
  - ☐ Oral appliance
- ☐ Other: _____

YES NO DK **Stomach/Intestine/Liver disorder**

If yes, please specify:

- ☐ Acid reflux (GERD)
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Ulcerative colitis
- ☐ Celiac disease
- ☐ Hepatitis
  - ☐ A ☐ B/D ☐ C
- ☐ Cirrhosis
- ☐ Other: _____

YES NO DK **Eating disorder**

If yes, please specify:

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

YES NO DK **Kidney/Urinary disorder**

If yes, please specify:

- ☐ Chronic kidney disease
- ☐ Renal failure/Dialysis
- ☐ Bladder problems
- ☐ Urinary incontinence
- ☐ BPH (Benign Prostate Hypertrophy)
- ☐ Other: _____

YES NO DK **Muscle/Bone disorder**

If yes, please specify:

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Fibromyalgia
- ☐ Other: _____

YES NO DK **Skin problem**

If yes, please specify:

_____

YES NO DK **Neurologic/Nerve problem**

If yes, please specify:

- ☐ Stroke
- ☐ TIA (Transient Ischemic Attack)
- ☐ Seizures/Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies (tingling, numbness)
- ☐ Dementia/Alzheimer's (memory loss)
- ☐ Autism
- ☐ Headache
- ☐ Other: _____

YES NO DK **Mental Health disorder**

If yes, please specify:

- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ PTSD (Post Traumatic Stress Disorder)
- ☐ ADD/ADHD (Attention Deficit Disorder)
- ☐ Generalized anxiety disorder
- ☐ Panic attacks
- ☐ Other: _____

YES NO DK **Diabetes/Endocrine disorder**

If yes, please specify:

- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
- ☐ Thyroid problems
  - ☐ Hypothyroidism (low)
  - ☐ Hyperthyroidism (high)
- ☐ Other: _____

YES NO DK **Blood/Hematologic disorder**

If yes, please specify:

- ☐ Anemia
- ☐ Sickle cell disease/trait
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ Von Willebrand Disease
  - ☐ Thrombocytopenia (low platelets)
- ☐ Other: _____

YES NO DK **Immune System disorder**

If yes, please specify:

- ☐ Lupus erythematosus
- ☐ Rheumatoid arthritis
- ☐ Sjögren's syndrome
- ☐ Other: _____

YES NO DK **Infectious disease**

If yes, please specify:

- ☐ HIV/AIDS
- ☐ STD (Sexually Transmitted Disease)
- ☐ Cold sores
- ☐ Other: _____

YES NO DK **Do you have any other problem, disease or condition not listed above?**

If yes, please specify:

_____

_____

ANESTHETIC HISTORY

YES NO DK **Anesthesia problems**

- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Prolonged/difficulty waking up
- ☐ Post-operative nausea and vomiting
- ☐ Other (Specify): _____

FEMALES ONLY:

YES NO DK Are you or could you be pregnant? If yes, number of weeks _____ and due date: _____
YES NO DK Are you nursing?
YES NO DK Are you taking any of the following? (Specify): BIRTH CONTROL FERTILITY DRUGS HORMONE REPLACEMENT

ALLERGIES TO DRUGS OR LATEX:

YES NO DK **Are you allergic to or have you had a reaction to any of the following? Please specify type of reaction:**

- ☐ Local anesthetics (Lidocaine/Epinephrine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other antibiotics (Specify): _____
- ☐ Aspirin
- ☐ Advil (Ibuprofen)
- ☐ Tylenol (Acetaminophen)
- ☐ Codeine
- ☐ Opioids (hydrocodone, oxycodone)
- ☐ Chlorhexidine mouth rinse (Peridex/Periguard)
- ☐ Metals/Jewelry (nickel/chrome)
- ☐ Other Medication(s) (Specify): _____
- ☐ Dietary allergies
- ☐ Latex (rubber)

Reaction(s) to above: _____

MEDICATIONS:

YES NO DK **Are you taking, or are you supposed to be taking any medications - prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below.**

Medications or Supplements: Prescription, over the counter, dietary supplement, herbal medicines and vitamins	**Dose** (mg)	**How Often:** (once a day, twice a day, etc.)	**Date Started:**	**Reason for Use:**

Name:_____ Date:_____

COMANCHE
DENTAL

PATIENT RELEASE/HIPAA/FINANCIAL POLICY

Thank you for the confidence you have shown in choosing us to provide for your dental needs. We are pleased to assist with your insurance; however, you are ultimately responsible for payment of your bill.

1. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.
_____**Please Circle: Spouse Parent Child Other**

Signature of Patient/Legal Guardian: _____**Date:** _____

2. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I acknowledge that the Notice of Privacy Practices is available at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

Signature of Patient/Legal Guardian: _____**Date:** _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but this could not be obtained because:
___ *Individual refused to sign*
___ *Communications barriers prohibited obtaining the acknowledgement*
___ *an emergency situation prevented us from obtaining the acknowledgment*
___ *Other:*
Employee Signature: _____ *Date* _____

---

3. FINANCIAL RESPONSIBILITY: I understand I am personally responsible for any fees I incur for services rendered. I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at time of service. Finance charges may be assessed against overdue accounts. In the event any fees are unpaid and it becomes necessary to pursue collection efforts, I agree to pay all costs directly associated with such collection efforts.
I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Ryan L. Seegmiller DDS.

Signature of Patient/Legal Guardian: _____**Date:** _____

4. Broken/Missed Appointments: We request at least 24 hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and fill the opening left in our schedule. We reserve the right to charge your account $50 if we are not notified at least 24 hours before your appointment.
Thank you for assisting us in keeping our schedule full.

Signature of Patient/Legal Guardian: _____**Date:** _____