welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

Form No. T110R

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

STUBBS FAMILY DENTISTRY Medical History

Patient Name: (last) _____ (first) _____ (middle) _____

Sex (circle one): Male Female Date of Birth: _____

1. Have you been hospitalized in the last 5 years due to surgery of illness?
2. Are you undergoing any medical treatment?
3. Are you taking any prescription medications or over the counter supplements?
4. Are you currently undergoing, or have you ever had, Bisphosphonate therapy (Fosamax, Boniva, Reclast, Aredia, Zometa)?
5. Any allergies to medications or environment or medical supplies?
6. Have you ever had a reaction to any medications given to you?
7. Do you bleed abnormally after cuts or extractions?
8. Have you ever had radiation therapy?
9. Have you taken steroids (Cortisone) in the last 2 years?
10. Do you smoke, use smokeless tobacco, or vape? How much/ often? _____
11. For Women: Are you pregnant? _____ (Due date) _____
12. Are there any other physical, mental, or emotional problems we should be aware of?
13. Please check if you have or had any of the following conditions:

- ☐ AIDS/ HIV
- ☐ Alcohol/ Drug/ Marijuana addiction
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cold Sores
- ☐ Congenital Heart Defect
- ☐ COPD/ Emphysema
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ Glaucoma
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Hepatitis A / B / C / D
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Mental Health Disorder
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Sleep Apnea Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ/ Jaw Disorders
- ☐ Tuberculosis
- ☐ Artificial Heart Valve
- ☐ Parathyroid Disease

Please explain any checked responses: _____

Patient Signature _____ **Date** _____

Doctor Signature _____ **Date** _____

Stubbs Family Dentistry

HIPPA Patient Consent Form

2323 S. 109th Street, Suite 300, West Allis, WI 53227

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and dental certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the above address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____

Witness Signature: _____