STUBBS FAMILY DENTISTRY Registration

Patient Information

Date:____________________

Patient Name: (last)________________________________ (first)______________________________ (middle)____________________

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

□ Married □ Single □ Child □ Other Social Security#:______________________

Phone (Home):________________ (Work): _________________ (Cell): ___________________

Email Address: ___________________________

What is your preferred method of contact? □ Home □ Cell □ Texting □ Email

Home Address: (Street)_____________________________ (City/State):_______________________ (Zip):____________

Employer Name: _________________________ Emergency Contact Name & Phone: ____________________________

Spouse/Parent Name: ______________________ Who is responsible for this account: ____________________________

Patient/Parent Social Security #:____________________ (Only for insurance purposes)

Dental Insurance

Employee Name:____________________________ Employee Date of Birth:________________________

Relationship to Patient:________________________ Employer Name:_____________________________

Name of Insurance Company:___________________ Address:___________________________________

Insurance Phone Number:___________________ Member ID#:_______________ Group#:______________________

Referral Information

Can we thank someone for referring you? ______________________________

Or did you find us on your own? □ Website □ Internet/Google □ Location □ Other________________

We Love referrals! For each referral you send to us, we will send you a gift card as a way of saying Thank You!
(Does not include referrals of immediate family members)

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 of 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 service not paid by my dental care payor.

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

Parent or Guardian's Signature: ______________________________ Date:________________________

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

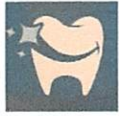
Please explain any checked responses: _______________

____

____

Patient Signature _______________ **Date** ____________

Doctor Signature _______________ **Date** ____________



STUBBS FAMILY DENTISTRY Dental History

Patient Dental History

Date:______________________________ Patient Name:____

Name of Previous Dentist____ Date of Last Exam_________________________

Previous Dentist's Location____ Date of Last Cleaning______________________

Did you recently have xrays taken at your prior office, in the past 2 years & what office was it?____________________________

		Yes	No
1.	Do you require antibiotics before dental treatment?	☐	☐
2.	Do you brush daily?	☐	☐
3.	Do you floss daily?	☐	☐
4.	Do your gums bleed while brushing or flossing?	☐	☐
5.	Are your teeth sensitive to hot or cold liquids or foods?	☐	☐
6.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
7.	Do you feel pain to any of your teeth?	☐	☐
8.	Do you experience dry mouth?	☐	☐
9.	Do you have any sores or lumps in or near your mouth?	☐	☐
10.	Have you had any head, neck or jaw injuries?	☐	☐
11.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐
12.	Do you have frequent headaches?	☐	☐
13.	Do you clench or grind your teeth?	☐	☐
14.	Does your jaw click or pop?	☐	☐
15.	Does food get caught in your teeth?	☐	☐
16.	Do you bite your lips or cheeks frequently?	☐	☐
17.	Have you ever had any difficult extractions in the past?	☐	☐
18.	Have you ever had any prolonged bleeding following extractions?	☐	☐
19.	Have you had any orthodontic treatment?	☐	☐
20.	Do you wear dentures or partials?	☐	☐
	If YES, date of placement__________________________		
21.	Do you have any implants?	☐	☐
22.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
23.	Do you like your smile?	☐	☐

I certify that the above information is complete and accurate

Patient's Signature:_____________________________________ **Dentist Signature:**_____________________________

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 or your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I will be given a copy of my Notice of Privacy Practices, if I request one. I understand that this office has the right to change its Notice of Privacy Practices from time to 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 our 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:________________________________