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

2323 South 109th Street, Suite 300

West Allis, WI 53227

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protection health information. I understand that this information can and will be used to:

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

Patent Name: _____ Date: _____

Signature: _____

Witness Signature: _____

Stubbs Family Dentistry, L.L.C.

Yvonne D. Stubbs, D.D.S.

2323 South 109th Street, Suite 300

West Allis, WI 53227

Phone: 414 541 8250

Fax: 414 541 8241

Authorization to Release or Disclose Health Information

Name of Patient: _____

Date of Birth: _____

I request and authorize Dr. Yvonne D. Stubbs/ Stubbs Family Dentistry, L.L.C. to release my protected health information to the family members and others listed below for the purpose of communicating results, findings, and care decisions including financial and insurance matters.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This request and authorization apply to healthcare information related to examinations or treatment performed at Stubbs Family Dentistry, L.L.C., West Allis, WI.

I understand I can cancel this agreement by sending the above office a letter revoking this authorization.

_____

Signature of Patient or Representative Date

Stubbs Family Dentistry, L.L.C.

2323 South 109th Street, Suite 300

West Allis, WI 53227

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

I consent to receiving electronic communications from Stubbs Family Dentistry, L.L.C. via e-mail and phone text messages.

I am aware that that there is some level of risk that third parties might be able to read unencrypted e-mails and text messages.

I am responsible for providing the dental practice any updates to my e-mail address or cell phone number.

I can withdraw my consent to electronic communications by calling

414 541 8250 (phone number for Stubbs Family Dentistry, L.L.C.)

or

by sending an e-mail to

ystubbsddsoffice@gmail.com

Patient Signature: _____ Date: _____