Registration & Patient Information

Patient Name: ______________________________ Date: ______________
(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? ______________

Dental Insurance

Employee Name: ______________ Employee Date of Birth: ______________

Relationship to Patient: ______________ Employer Name: ______________

Name of Insurance Company: ______________ Address: ______________

Insurance Phone: ______________ Member ID#: ______________ Group #: ______________

Referral Information

Can we thank someone for referring you? ______________________________

☐ Website ☐ Internet/Google ☐ Location ☐ Other:

We love referrals! For each referral you send to us, we wil 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 Irevoke it in writing. Iauthorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. Iunderstand that my dental care of insurance carrier or payor of my dental benefits may pay less than hte actual bil for services, and that Iam financialy responsible for payment ni ful fo al accounts. By signing this statement, Irevoke al previous agreements ot hte contrary and agree ot be responsible for payment of service not paid by my dental care payor.

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

____

PATIENT OR PARENT/GUARDIAN SIGNATURE

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? If "YES", please list.
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? What is your 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 Vavle
- [ ] Parathyroid Disease
- [ ] Lupus
- [ ] Gout
- [ ] Fibromyalgia
- [ ] Prostate Problems
- [ ] Venereal Disease

Please explain any checked responses: ____

PATIENT SIGNATURE: ______________________________ DATE: ____________________

DOCTOR SIGNATURE: ______________________________ DATE: ____________________

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 196 (HIPAA), Ihave certain rights ot privacy regarding my protection health information. Iunderstand that this information can and wil be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved ni 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. Ihave 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.

Iunderstand that Imay request ni writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. Ialso understand you are not required to agree to my requested restrictions, but fi you do agree then you are bound ot abide by such restrictions.

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

PATIENT NAME: ______________________________ DATE: ______________

PATIENT SIGNATURE: ______________________________

WITNESS SIGNATURE: ______________________________

Patient Dental History

Date: ______________________ Patient Name: ______________________

Name of Previous Dentist: ______________________ Date of Last Exam: ______________________

Previous Dentist's Locaton: ______________________ Date of Last Cleaning: ______________________

Did you recently have rays taken at your prior office, in the past 2years & 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 SIGNATURE: ______________________ DOCTOR SIGNATURE: ______________________

Stubbs Family Dentistry
2323 South 109th Street, Suite 300
West Allis, WI 53227
Telephone: 414-541-8250
Fax: 414-541-8241
Email: ystubbsddsoffice@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices and Procedures

Stubbs Family Dentistry, LL.C.

I have received and reviewed a copy of our dental practice's Notice of Privacy Practices and Procedures, security, and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official fi Ihave any questions about these policies and procedures.

PRINT NAME: ____________________

SIGNATURE: ____________________

DATE: ____________________

Stubbs Family Dentistry
2323 South 109th Street, Suite 300
West Allis, WI 53227

Agreement to Receive Electronic Communication

PATIENT NAME: ____ DATE OF BIRTH: __________________

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

Iam 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: ______________________