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 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. Iunderstand 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 final 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: ____________

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 o 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 1996 (HIPAA), I have certain rights to privacy regarding the protection of my 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.

PATIENT NAME: ______________________________ DATE: ______________

PATIENT SIGNATURE: ______________________________

WITNESS SIGNATURE: ______________________________

Patient Dental History

Patient Name: ____ Date: ______________

(Last) (First) (Middle)

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

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

Did you recently have x-rays 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 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 if I have 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 to receiving electronic communications from Stubbs Family Dentistry, L.L.C. via email and phone text messages.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails and text messages. I am responsible for providing the dental practice with any updates to my email 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 email to ystubbsddsoffice@gmail.com.

PATIENT SIGNATURE: ____ DATE: ______________________