PATIENT REGISTRATION

Last Name First M.I.

Preferred Name

Physical Address City State Zip Code

Mailing Address If Different

Home Phone

Work Phone

Cell Phone

Email Address

Date of Birth Age

Male Female

Single Married Other

Social Security #

Drivers License #

Your Occupation

Employers Name

Your Spouse's Occupation

Employer's Name

Who Can We Thank For Referring You

Other Family Members That Are Patients

Person To Contact for Emergency

Phone Number

Please Circle the Top TWO ways in which you would like to be contacted:

Email Text Message Telephone

INSURANCE INFORMATION

Insurance Company

Group Number

Insured's Name

Employer Name

Date of Birth

Relationship to Patient

Insured's I.D. #

Insured's Social Security #

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Relationship to Patient

Address City State Zip Code

Phone Number

Social Security #

Date of Birth

Drivers License #

Jeffrey W. Berger D.D.S. ~ Redefining Excellence

Patient Name: ____

Patient Address: ____

Phone #:______________________ Email address:______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Have you been under the care of a medical doctor during the past two years?
If yes, for what? ____
Physician's name______________________ Phone______________________
Please list any medications you are taking and what it is for:

1. ____
2. ____
3. ____
4. ____

Medical History

Please circle any of the following that apply to you:

Acid Reflux
AIDS/HIV
Allergies (seasonal)
Anemia
Arthritis/ Rheumatism
Artificial Heart Valve
Artificial Joints
Asthma
Bisphosphonates IV
Blood Disease
Bruise Easily
Cancer
Chemotherapy
Cold Sores
Cortisone Medicine
Drug Addiction
Emphysema
Excessive Bleeding
Fainting / Dizziness
Gastric bypass surgery
Glaucoma
Heart Conditions
Heart Murmur
Hemophilia
Hepatitis A B C (circle)
High Blood Pressure
Jaundice
Jaw Joint Pain
Kidney Disease
Latex Sensitivity
Liver Disease
Low Blood Pressure
Pacemaker
Pre-Medication for dental work
Pregnant or Nursing
Radiation (head / neck)
Respiratory Problems
Stomach Problems
Stroke
Thyroid Problems
Tuberculosis
Tumors
Ulcers
Venereal Disease
Other____________________

DIABETIC – Please Circle
Type I Type II What is Your Blood Sugar Level __________
How Often do you test it? __________

Do you have any of the following drug allergies?

Aspirin
Clindamycin
Local Anesthetic
Nitrous Oxide
Penicillin
Percocet
Sulfa
Valium
Other____________________

When you are thirsty what do you like to drink? ______________________________
When you want a snack what is it you choose to eat? ______________________________

Please share the following dates:
Your last cleaning _____ / _____   Last Oral Cancer Screening _____ / _____   Last Complete X-Rays _____ / _____

Previous Dentist's Name ________________________________   Phone# ________________________
What is your reason for changing Dentists? ____

How often do you brush? ______________________________   Floss? ___________________________________
What home care aids do you use? ____

On a scale of 1 – 10, with 10 being the most severe, How would you rate your dental anxiety? _________

Please check any of the following problems that apply to you

- ❑ Sensitivity (please circle which one applies) Cold, Hot, Sweet
- ❑ Tooth pain or discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath or bad taste in your mouth

Do you or have you had any of the following?

- ❑ Dentures
- ❑ Partial Dentures
- ❑ Braces (traditional or invisalign)
- ❑ Periodontal disease(deep cleaning)
- ❑ Implants

- ❑ **If you could whiten your teeth for an affordable price, would you do it?**   **Yes**   **No**

- ❑ **Smoke or use chewing tobacco?**   How Much?   For how long?

- ❑ **Would you like to keep your teeth all of your life?**   **Yes**   **No**

If I could change my smile, I would:

- ❑ Make them brighter
- ❑ Make them straighter
- ❑ Close spaces
- ❑ Replace black metal fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?   1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?   1 2 3 4 5 6 7 8 9 10

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient / Guardian Signature____   Date____________________

Dentist Signature____   Date___________________

ACKNOLEDGEMENT
OF
PRIVACY PRACTICES

Jeffrey W. Berger D.D.S.
19604 Mono Way
Sonora, CA 95370
(209) 532-2915

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to :

- *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment information from third-party payers for my health care services.*
- *Conduct normal health care operations such as quality assessment and improvement activities.*

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above 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 care options and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

*Patient Name:*___________________________________ *Date:*_____________________________

*Signature:*______________________________________

*Relationship to Patient:*___________________________

Dependent family members also covered by this acknowledgement:

____

With whom may we share information about your dental needs / care: ____________________________

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