TIME 10:24 AM DATE 8/15/2017

# PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

## Responsible Party ( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

### Section 3

Cell Phone Number

Pager Number

## Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

## Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Interlakes
FAMILY DENTAL

Acknowledgement of Receipt Notice of Privacy Practices

## Consent to Share Information

I, (print name) _____, give permission to share information regarding my treatment and/or finances to (check all that apply):

- Parent Name: _____
- Spouse Name: _____
- Guardian Name: _____
- Other: _____

I also give permission for messages to be left on my home, work, or personal voicemail for confirmation of appointments or to communicate insurance or account information.

_____ _____

Patient Signature Date

## HIPAA Privacy Notice

I, (print name) _____, have read and understand the notice of privacy practices at Interlakes Family Dental Center and acknowledge that I may request a copy of the document at any time.

_____ _____

Patient Signature Date

*You may refuse to sign this acknowledgment*

**Office Use Only**

- Acknowledgement could not be obtained due to:
- Refusal to sign
- Communication barriers prohibited information consent
- An emergency situation prevented our ability to obtain acknowledgement
- Other: _____

Office Team Member: _____ Date: _____

Interlakes
FAMILY DENTAL

Please sign below after you read and understand our programs and policies.

## Referrals

For every new patient, you refer to Interlakes Family Dental Center you will receive $25 account credit to be used in our office. The credit will be applied to your account when the new patient has completed this form * with your name written in the "Who may we thank for inviting you?" section. *

**Who may we thank for inviting you?**

- Current Patient: _____
- Through my dental insurance company
- On the internet
  - Google
  - Yahoo
  - Bing
  - Yelp
  - Facebook
  - Healthprofs.com
  - Healthgrades.com
  - Other (please specify): _____

## Financial Policy

Compensation for services is due when treatment is performed. Payment options include: cash, check, credit card, or third party financing through Care Credit or Lending Club Payment Solutions. We want to help you achieve your goals, so if you would like to discuss payment options please speak with Lisa, our Treatment Coordinator.

## Missed Opportunity Policy

We are dedicated to giving you the best care possible. If you are unable to keep your appointment, please give us at least 24 hours notice so someone else may have the opportunity to use the time we have reserved for you. If you cancel last minute, or do not come to a scheduled appointment due to a non-emergency, we will charge you $50 for a missed opportunity with the doctor and/or $30 for a missed opportunity with your dental hygienist. Thank you in advance for your cooperation in ensuring a smooth-running schedule.

Patient Signature: _____ Date: _____

60 Whittier Hwy, Suite 1, Moultonborough, NH 03254 InterlakesDental.com P: 603-253-4363 F: 603-253-4148

Interlakes
FAMILY DENTAL

# Official Record Release

Please forward all records for the following patients to **TOOTHMAIL@INTERLAKESDENTAL.COM**

Patient Name: D.O.B:

_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous Office Information: _____

Printed name of patient or guardian: _____

Signature of patient or guardian: _____

Date: _____/_____/_____

# Customized Medical History (Revised)

Patient Name: Birth Date: Date Created:

## Physician, Medications and Allergies

| | | |
|---|---|---|
| Do you have a primary care physician? Please list location and phone number | Yes No | If yes |
| Are you under a physician's care now? | Yes No | If yes |
| Have you been hospitalized or had a major operation? If so please list surgery and date | Yes No | If yes |
| Have you had a joint replacement? If so please list doctor name, location, and date of surgery | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medication, supplements, vitamins, or drugs? If so, what do you take? | Yes No | If yes |
| Do you take Coumadin or other blood thinners? | Yes No | If yes |
| Are you on a special diet? | Yes No | If yes |
| Do you drink alcohol? If so, How much? | Yes No | If yes |
| Do you use tobacco? If so, how long and how much? | Yes No | If yes |
| Do you use controlled substances? | Yes No | If yes |

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| Acrylic | Gluten | Local Anesthetics | Penicillin |
| Aspirin | Iodine | Metal | Sulfa Drugs |
| Latex | | | |

| | | |
|---|---|---|
| Do you have any other allergies? If so please list | Yes No | If yes |

## Past Dental Experience

| | | |
|---|---|---|
| Have you ever had a difficult dental experience? | Yes No | If yes |
| Have you ever had orthodontic treatment? If so, please list doctor, phone number, and date | Yes No | If yes |
| Have you ever been diagnosed with periodontal disease? If so, please list doctor's name, phone | Yes No | If yes |

## Oral Health

Do you have, or have you had, any of the following?

| | |
|---|---|
| Difficulty Swallowing | Yes No |
| Excessive Thirst | Yes No |
| Bad Breath | Yes No |
| Dry Mouth | Yes No |
| Neck or Jaw Pain/Discomfort | Yes No |
| Clenching or Grinding your teeth | Yes No |

| | | |
|---|---|---|
| Is your water fluoridated? | Yes No | |
| Do you wear Retainers or a Night Guard? Please | Yes No | If yes |
| Do you wear dentures or partials? | Yes No | If yes |
| Do you think you have a healthy mouth? | Yes No | |
| Would you change anything about your smile? If so, what would you change? | Yes No | If yes |

## Women

Women: Are you...

| | | |
|---|---|---|
| Pregnant/Trying to Get Pregnant | Nursing | Taking oral contraceptives? |

| | | |
|---|---|---|
| Have you ever had pregnancy complications? | Yes No | If yes |

## Family History

Has anyone in your immediate family been diagnosed with any of the following? If so, who?

| | | | |
|---|---|---|---|
| Alzheimer's Disease | Yes No | If yes | |
| Cancer | Yes No | If yes | |
| Diabetes | Yes No | If yes | |
| Heart Attack/Failure | Yes No | If yes | |
| Periodontal Disease | Yes No | If yes | |
| Thyroid Problems/Disease | Yes No | If yes | |

## Diseases

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Acid Reflux/Gerd | Yes No | AIDS/HIV Positive | Yes No | Alzheimer's Disease | Yes No | Anaphylaxis | Yes No |
| Anemia | Yes No | Angina/Chest Pain | Yes No | Anxiety | Yes No | Arrhythmia | Yes No |
| Arthritis | Yes No | Artificial Heart Valve | Yes No | Artificial Joint | Yes No | Asthma | Yes No |
| Autism Spectrum Disorder | Yes No | Automimmune Disorder | Yes No | Blood Disease | Yes No | Blood Thinners | Yes No |
| Blood Transfusion | Yes No | Breathing problems | Yes No | Bruise easily | Yes No | Cancer | Yes No |
| Chemotherapy | Yes No | Cold Sores/Fever Blisters | Yes No | Congenital Heart Disease | Yes No | Convulsions | Yes No |
| COPD | Yes No | Cortisone Medicine | Yes No | Diabetes (Type I) | Yes No | Diabetes (Type II) | Yes No |
| Difficulty Sleeping | Yes No | Drug Addiction | Yes No | Easily Winded | Yes No | Emphysema | Yes No |
| Epilepsy or Seizures | Yes No | Excessive Bleeding | Yes No | Fainting Spells/Dizziness | Yes No | Frequent Cough | Yes No |
| Frequent Diarrhea | Yes No | Frequent Headaches | Yes No | Glaucoma | Yes No | Gout | Yes No |
| Hay Fever/Seasonal | Yes No | Heart Attack/Failure | Yes No | Heart Murmur | Yes No | Heart Pacemaker | Yes No |
| Heart Trouble/Disease | Yes No | Hemophilia | Yes No | Hepatitis A | Yes No | Hepatitis B or C | Yes No |
| Herpes | Yes No | High Blood Pressure | Yes No | High Cholesterol | Yes No | Hives or Rash | Yes No |
| Hypoglycemia | Yes No | Inflammatory Disease | Yes No | Irregular Heartbeat | Yes No | Irritable Bowel Syndrome | Yes No |
| Jaundice | Yes No | Kidney Disease | Yes No | Kidney Stones | Yes No | Leukemia | Yes No |
| Liver Disease | Yes No | Low Blood Pressure | Yes No | Lung Disease | Yes No | Lyme Disease | Yes No |
| Migraines | Yes No | Mitral Valve Prolapse | Yes No | Osteoporosis | Yes No | Parathyroid Disease | Yes No |
| Parkinson's Disease | Yes No | Pre Eclampsia | Yes No | Psychiatric Care | Yes No | Radiation Treatments | Yes No |
| Recent Extreme Weight Loss | Yes No | Renal Dialysis | Yes No | Rheumatic Fever | Yes No | Rheumatism | Yes No |
| Scarlet Fever | Yes No | Shingles | Yes No | Sickle Cell Disease | Yes No | Sinus Trouble | Yes No |
| Spina Bifida | Yes No | Stomach/Intestinal Disease | Yes No | Stroke | Yes No | Swelling of Limbs | Yes No |
| Thyriod Disease | Yes No | Tonsillitis | Yes No | Tuberculosis | Yes No | Tumors or Growths | Yes No |
| Ulcers | Yes No | Vascular Dysfunction | Yes No | Venereal Disease | Yes No | | |

| | | | |
|---|---|---|---|
| Have you ever had any serious illness not listed | Yes No | If yes | |
| Have you ever taken Fosamas, Boniva, Actonel, or any other medications containing bisphosphonates? | Yes No | If yes | |
| Have you ever taken Phen-Fen or Redux? | Yes No | If yes | |

## Comments - Please list any additional doctors not listed above

## Emergency Contact name and phone number

## Signature

Signature of Patient, Parent or Guardian:

X_____ Date:_____