

# Catalina Dental Patient Registration

## Please Complete the Following *Confidential* Patient Information

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Name You Prefer To Be Called: \_\_\_\_\_ Do You Prefer Calls At: Home Work Cell

Please Circle the Following: Male Female Married Single Divorced Widowed Other

Whom may we Thank for Referring You? \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Person to Contact in Case of Emergency? \_\_\_\_\_ Contact Phone \_\_\_\_\_

## Please Read and Sign the Following *Privacy Information (HIPAA)*

My signature below indicates that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the full Notice of Privacy Practices is posted in the reception room and is available to me upon my request.

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**

## Please read the Following *Authorization, Release, and Agreement*

I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior arrangements have been made. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I understand that a fee of \$40.00 may be assessed for appointment changes with less than 48 hours notice.

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**

# Catalina Dental Medical/Dental History

Please Complete the Following *Confidential* Medical/Dental History Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_  
Medical Specialists: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_  
\_\_\_\_\_ Dr. Phone #: \_\_\_\_\_

Have you been in Hospital in the last 3 years? Yes No Please explain Procedures/Conditions: \_\_\_\_\_

Do you take an antibiotic pre-medication prior to dental visits? Yes No Name of Medication: \_\_\_\_\_

Please List ALL Medications/Supplements you currently take: \_\_\_\_\_  
\_\_\_\_\_

Do you have any Allergies to medications or materials? \_\_\_\_\_

Do you use tobacco? If yes please give type and frequency: \_\_\_\_\_

Have you ever had abnormal/prolonged bleeding? \_\_\_\_\_

For Women Only: Are you pregnant/nursing/using birth control? \_\_\_\_\_

**Please mark YES or NO for each item that you have now or have had before:**

No Yes AIDS or HIV	No Yes Epilepsy/Seizures	No Yes Kidney Disease	No Yes Substance Abuse
No Yes Arthritis	No Yes Fainting	No Yes Low Blood Pressure	No Yes Thyroid Problems
No Yes Asthma	No Yes Glaucoma	No Yes Mitral Valve Prolapse	No Yes Tuberculosis
No Yes Anemia	No Yes Heart Murmur	No Yes Pace Maker	No Yes Weight Gain/Loss
No Yes Alzheimer's	No Yes Heart Disease	No Yes Psychiatric Therapy	No Yes Sensitive Teeth
No Yes Blood Transfusion	No Yes Heart Valves (Artificial)	No Yes Radiation/Chemo Therapy	No Yes Frequent Headaches
No Yes Cancer	No Yes Heart Attack	No Yes Rheumatic Fever	No Yes Head/Neck Injuries
No Yes Cold Sores	No Yes Hemophilia	No Yes Shingles	No Yes Jaw Clicks/Pops/Pain
No Yes Chest Pains	No Yes Hepatitis	No Yes Sickle Cell Disease	No Yes Clench/Grind
No Yes Colitis	No Yes High Blood Pressure	No Yes Sinus Problems	Anything not Mentioned: _____
No Yes Diabetes	No Yes Jaundice/Liver Disease	No Yes Stomach Problems/Ulcers	
No Yes Emphysema	No Yes Joint Replace/Implants/Stents	No Yes Stroke	

Any Family History of: Diabetes Heart Disease Cancer Gum Disease Other

Which Family Member? \_\_\_\_\_

Do you have any Dental Problems Currently? \_\_\_\_\_

Please Explain any Positive or Negative Dental Experiences? \_\_\_\_\_  
\_\_\_\_\_

In what ways can we make your Dental visits better? \_\_\_\_\_  
\_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_

*I certify that I have responded to the above information and to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.*

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_