

**Dr. Kegler and Associates
Family Dentistry
592B Medical Park Dr
Gainesville, GA 30501**

NEW PATIENT REGISTRATION

Today's Date: _____ Whom May We Thank for Referring You? _____

Patient Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: M F Social Security Number: _____

Street Address: _____

City _____ State: _____ ZipCode: _____

Home Phone# _____ Work # _____

Cell Phone #: _____ Email: _____

Patient Occupation or School: _____ Work Phone # _____

Business Name and Address: _____

City: _____ State: _____ ZipCode: _____

Spouse's Name and Occupation: _____

Spouse's Employer and Address: _____

City: _____ State: _____ ZipCode: _____

Spouse's Work Phone # and Extension: _____

Person to Contact in Case of Emergency: _____ Phone #: _____

Nearest Relative Not Living with You: _____ Phone #: _____

Name of Insured: _____ Social Security #: _____

Insured's Employer Name: _____ Dental Insurance Name: _____

Policy # if different than Social Security #: _____ Group #: _____

Insurance Company Phone #: _____ Insured's DOB: _____

NEW PATIENT HEALTH HISTORY FORM

PATIENT NAME: _____ DATE: ____/____/____

DIRECTIONS: The following information about your health history is very important to us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you do not understand, unsure of an answer, or would like to discuss an item with Dr. Kegler, circle the number or word. This Health History Questionnaire will become a part of your dental treatment record and will be considered confidential information. If you are completing this for a minor child or dependant, answer as per their history.

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? YES/NO
2. Have you been under the care of a physician during the past two years? YES/NO
Physician's Name _____ Phone # _____
3. Have you taken any medication during the past two years? YES/NO
Are you taking medications, drugs, or pills? YES/NO
If yes, please list those drugs and conditions they treat: _____

4. Do you have any drug allergies? YES/NO If yes, to what medications? _____

5. Do you have or have you ever had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Fever Blisters/Cold Sores |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Conditions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Heart Valve or Joints | <input type="checkbox"/> Ulcer/Stomach Disorders | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug or Alcohol Addition |
| <input type="checkbox"/> H. I. V. Positive | <input type="checkbox"/> Asthma or Bronchitis | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Hay Fever or Sinus | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |

6. Do your ankles swell? YES/NO
7. Severe or frequent headaches? Sinus Problems? YES/NO
8. Phobias, severe anxieties, depression, psychoses, unusual fears or other related conditions?
YES/NO
9. Do you have complaints/conditions regarding your eyes, ears or nose? YES/NO
10. Do you smoke? YES/NO If yes, how many packs per day? _____

11. If you drink alcohol, how many drinks per week do you consume? _____

FOR WOMEN ONLY

Are you pregnant? Yes No If yes, what month? _____
If no, are you taking birth control pills? Yes No

DENTAL HISTORY

- 1. What is your dental concern?

- 2. Date of your last dental visit and cleaning?

- 3. Date you last had dental x-rays taken? _____
- 4. What would you do to change your smile?

- 5. Do you brush and floss daily? YES?NO
- 6. Have you always had your teeth cleaned once per year? YES/NO
- 7. Do you gums bleed when your brush or teeth or when you eat? YES/NO
- 8. Does food or dental floss catch between your teeth? YES/NO
- 9. Are your teeth sensitive to hot, cold or pressure? YES/NO
- 10. Do you experience pain or clicking in your jaw joints? YES/NO
- 11. Have you had any injury to your teeth, jaws or face? YES/NO If yes, explain:

- 12. Are you worried or nervous about having dental treatment? YES/NO
- 13. Have you ever fainted during a dental visit? YES/NO If yes, explain:

- 14. Have you experienced an unusual reaction to dental medication or anesthetic? YES/NO
- 15. Have you experience prolonged bleeding following dental treatment? YES/NO
- 16. Have you had any other complications following dental treatment? YES/NO If yes, explain:

- 17. Do you have any other dental concerns or complaints? YES/NO If yes, explain:

Patient or Parent Signature: _____ Date: _____

(DOCTOR'S USE) HISTORY REVIEW

Reviewed By: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient#: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Laura Rodriguez
Telephone: 770-536-6688 Fax: 770-536-7070
Address: 592-B Medical Park Drive, Gainesville, Georgia 30501

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treatment you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of
Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but
acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

