PATIENT REGISTRATION

NAME (LAST, FIRST, MIDDLE (NICKNAME)) | DATE OF BIRTH | PRESENT AGE | S M D W C

ADDRESS | CITY | STATE/PROV. | ZIP/P.C.

HOME PHONE / CELL PHONE	FAMILY PHYSICIAN / MEDICAL ALERT
SS #/SIN / E-MAIL	NEAREST RELATIVE
EMPLOYER / OCCUPATION	PHONE
ADDRESS	ADDRESS
PERSON RESPONSIBLE FOR ACCOUNT	**CREDIT REFERENCES**
NAME / RELATIONSHIP	BANK
ADDRESS	CHECKING ACCOUNT NO.
SS #/SIN / E-MAIL	CREDIT CARD (S)
EMPLOYER / OCCUPATION	PREVIOUS EMPLOYER
ADDRESS	ADDRESS
INSURANCE INFORMATION	**INSURED DEPENDENT'S NAME**
INSURANCE COMPANY	SPOUSE / BIRTHDATE
NAME OF GROUP DENTAL PROGRAM	OTHER NAME
POLICY NUMBER / GROUP NUMBER	NAME
UNION LOCAL	RELATIONSHIP / BIRTHDATE
EFFECTIVE DATE OF INSURANCE / TIME LIMIT FOR CLAIMS	NAME
METHOD OF PAYMENT ☐ UCR ☐ SCHEDULE OF BENEFITS ☐ OTHER	RELATIONSHIP / BIRTHDATE
CO-INSURANCE: INSURANCE CO. SHARE / PATIENT'S SHARE	NAME
DEDUCTIBLE: ☐ YES ☐ NO $_____ AMOUNT	RELATIONSHIP / BIRTHDATE
IF YES: ☐ INDIVIDUAL ☐ FAMILY ☐ ANNUAL ☐ LIFETIME	NAME
COVERAGE	RELATIONSHIP / BIRTHDATE
	SECONDARY COVERAGE
	NAME OF SUBSCRIBER
	SUBSCRIBER'S S.S. NUMBER
EXCLUSIONS ☐ PROPHYLAXIS ☐ ORTHODONTICS	NAME & ADDRESS OF EMPLOYER
☐ OTHER	
STANDARD FORM ACCEPTED? ☐ YES ☐ NO	DENTAL PLAN NAME
	UNION LOCAL/GROUP NUMBER
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	CARRIER NAME & ADDRESS

ITEM 07-0513622/9834

PATIENT NAME _____

PATIENT REGISTRATION

MEDICAL – DENTAL HISTORY

PATIENT NAME _____ AGE _____ DATE _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

☐ YES ☐ NO Are you under any Medical treatment now?
☐ YES ☐ NO Have you had any major operations? If so, what? _____
☐ YES ☐ NO Have you ever had a serious accident involving head or jaw injuries?
☐ YES ☐ NO Have you had any adverse response to any drugs including penicillin and aspirin?
☐ YES ☐ NO Have you ever had any of the following?

- ☐ Heart Ailment
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Rheumatism or Arthritis
- ☐ Tumors or Growths
- ☐ Any Blood Disease
- ☐ Any Liver Disease
- ☐ Any Kidney Disease
- ☐ Any Stomach or Intestinal Disease
- ☐ Any Venereal Disease
- ☐ Yellow Jaundice or Hepatitis
- ☐ Epilepsy
- ☐ AIDS

☐ YES ☐ NO Are you on a diet at this time?
☐ YES ☐ NO Are you now taking drugs or medications?
☐ YES ☐ NO Are you allergic to any known materials resulting in - hives, asthma, eczema, etc?
☐ YES ☐ NO Do you have any reason to suspect you are <u>not</u> in good health?
☐ YES ☐ NO Have any wounds healed slowly or presented other complications?
☐ YES ☐ NO Are you pregnant?
☐ YES ☐ NO Do you have a history of fainting?
☐ YES ☐ NO Have you ever had any X-RAY TREATMENTS (other than diagnostic)?
☐ YES ☐ NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
☐ YES ☐ NO Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
☐ YES ☐ NO Have you ever taken Fen-Phen/Redux?
☐ YES ☐ NO Do you have a history of Tuberculosis?

PATIENT DENTAL HISTORY

☐ YES ☐NO Do you have any specific problems?
☐ YES ☐NO Do you have pain in or near your ears?
☐ YES ☐NO Do you have any unhealed injuries or inflamed areas in or around your mouth?
☐ YES ☐NO Have you experienced any growth or sore spots in your mouth?
☐ YES ☐NO Does any part of your mouth hurt when clenched?
☐ YES ☐NO Have you ever had Novocaine anesthetic?
☐ YES ☐NO Any reactions or allergic symptoms to novocaine?
☐ YES ☐NO Any difficult extractions in the past?
☐ YES ☐NO Have you had prolonged bleeding following extractions in the past?
☐ YES ☐NO Do your gums bleed?
☐ YES ☐NO Have you ever been instructed on the correct method of brushing your teeth?
☐ YES ☐NO Have you ever been instructed on the care of your gums?
☐ YES ☐NO Do you chew on only one side of your mouth?
☐ YES ☐NO Do you habitually clench your teeth during the night or day?
☐ YES ☐NO When was your last full mouth X-RAY taken? _____
Where? _____
☐ YES ☐NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?
If so, locate _____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____

Date _____

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

CURRENT MEDICATION	REASON	Date	Change	Signature

PATIENT'S NAME

MEDICAL / DENTAL HISTORY

_____

Michael J. Tobin, D.D.S., M.S., P.C.
PRACTICE LIMITED TO PERIODONTICS
DENTAL IMPLANTS - GUM DISEASE
NEW JERSEY LIC. #3613

1375 STATE, ROUTE 23
BUTLER, NJ 07405
(973) 838-4499

3339 ROUTE 94
MERCANTILE MALL
HARDYSTON, NJ 07419
(973) 827-5533
FAX: (973) 827-6602

PATIENT CONSENT FORM

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information (PHI) to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____
Patient's Signature Print Name

_____
Date

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

FOR OFFICE USE ONLY:
( ) Consent received by_____ Date:_____
( ) Consent added to patient's medical record on: _____
( ) Consent refused by patient, and treatment refused as permitted.