MASON
DENTAL CARE

PATIENT REGISTRATION

PHONE: 513. 336. 8510 | **FAX:** 513. 336. 7359

Patient Information:

Name: _____ (FIRST NAME) _____ (M.I.) _____ (LAST NAME) Birthdate: _____ Social Security #: _____

Address: _____ City: _____ Zip Code: _____

Gender: Male Female Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Spouse: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____ Email: _____

If Patient is a minor, please complete the following:

Name of person responsible for this account: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip Code: _____

Cell Phone: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____ Work Phone: _____

General Information:

General Dentist: _____ City: _____ Orthodontist: _____ City: _____

Other people involved in dental care: _____

General Physician: _____ City: _____ Emergency Contact: _____ Phone: _____

Dental Insurance Information:

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # OR ID #: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # OR ID #: _____

Medical Insurance Information:

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # OR ID #: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # OR ID #: _____

We would like to introduce you to our Appointment Reminder Program:

Reminder program is a way that we can make it easier for you to remember your appointment by sending you reminders via text message or email. Its benefits include being able to read the messages at your convenience without the interruption of a phone call. You are also able to confirm your appointment electronically. We understand your time is valuable and it's sometimes challenging to receive our calls. Do you consent to receiving text or email reminders? We will utilize the contact information provided above. ☐ YES ☐ NO

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MEDICAL & DENTAL HISTORY QUESTIONNAIRE

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Patient Name: _____ _____ _____ **Date:** _____
FIRST NAME M.I. LAST NAME

Current Medications & Supplements:

_____

Preferred Pharmacy: _____

Allergies & Symptoms: _____

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Do you have or have you had any of the following:

Heart Problems ..... YES NO
If yes, please describe: _____
High Blood Pressure ..... YES NO
Low Blood Pressure ..... YES NO
Pacemaker ..... YES NO
Artifical Heart Valve ..... YES NO
Joint Replacement ..... YES NO
If yes, please describe: _____
Is an antibiotic premed required before treatment? YES NO
If so, what type/dosage? _____
Easy Bruising ..... YES NO
Abnormal Bleeding ..... YES NO
Frequent Nose Bleeds ..... YES NO
Anemia ..... YES NO
History of Blood Transfusion ..... YES NO
History of Stroke or TIA ..... YES NO
Sinusitis ..... YES NO
Asthma ..... YES NO
Tuberculosis ..... YES NO
COPD ..... YES NO
Hepatitis, Type: _____ YES NO
Liver Problems ..... YES NO
Kidney Problems ..... YES NO
Bladder Problems ..... YES NO
Ulcers ..... YES NO
Gallstones or Gallbladder Problems ..... YES NO
Arthritis ..... YES NO
Back or Neck Pain ..... YES NO
Osteoporosis ..... YES NO
Osteopenia ..... YES NO
History of Fainting ..... YES NO
History of Seizures ..... YES NO

Epilepsy or other neurological disorder ..... YES NO
If other, what? _____
History of Head Trauma ..... YES NO
Frequent or Severe Headaches or Migraines ..... YES NO
Thyroid Concerns ..... YES NO
Diabetes, Type: _____, HbA1c: _____ YES NO
Family History of Diabetes ..... YES NO
Excessive Thirst ..... YES NO
Dry Mouth ..... YES NO
Oral Herpes or Cold Sores ..... YES NO
HIV+ or Acquired Immune Deficiency Syndrome ..... YES NO
Have you received an organ transplant? ..... YES NO
Have you donated an organ for transplant? ..... YES NO
Have you had cancer? ..... YES NO
If yes, type: _____
If yes, medication/treatment: _____
Have you taken Fosamax/Boniva/Actonel/Zometa? YES NO
Depression or Anxiety ..... YES NO
History of Alcohol Abuse ..... YES NO
History of Drug Abuse ..... YES NO
Do you smoke? ..... YES NO
If yes, how often? _____
Do you use smokeless tobacco? ..... YES NO
If yes, how often? _____

Women:

Pregnant, Due Date: _____ YES NO
Are you nursing? ..... YES NO
Contraceptives or Other Hormones ..... YES NO

Men:

Do you take medications for erectile dysfunction? YES NO
Do you have a history of prostate cancer? ..... YES NO

Other Medical Condition:

_____

How long have you been with your present general dentist? _____

Do any members of your family have or have they had in the past (please indicate relationship to you):

☐ Dentures _____ ☐ Periodontal Disease _____

Have you ever had any serious trouble associated with a previous dental experience? Please specify: _____

_____

Please list any other comments regarding your teeth, mouth, or dental history: _____

_____

Has there been an accident or medical event that may be the cause for you being here? If yes, please explain: _____

_____

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PATIENT AUTHORIZATIONS

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_____ ***I authorize*** the release of my dental records from Mason Dental Care and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Mason Dental Care.

_____ ***I authorize*** insurance payments to be made directly to Mason Dental Care. I understand I am responsible for any unpaid balance.

_____ ***I authorize*** the release of my photographs, radiographs, etc. to Mason Dental Care for the purpose of teaching, lecturing, and advertising.

_____ ***I am aware*** that should I not Provide adequate notice to change an appointment, I may be charged a fee. (7 calendar days for a surgical appointment and 2 business days for a cleaning appointment or exam.)

_____ ***I am aware*** of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice – Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize Mason Dental Care and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Mason Dental Care and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name: _____ Relationship to Patient: _____ Cell Phone: _____

Name: _____ Relationship to Patient: _____ Cell Phone: _____

☐ I do not authorize Mason Dental Care to discuss treatment and financial information with anyone other than myself.

Patient's Signature: _____ **Date:** _____