PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION DATE 2 1 **DENTAL INSURANCE** LAST NAME FIRST M.L PRIMARY CARRIER PREFERS TO BE CALLED BY INSURANCE COMPANY ADDRESS GROUP NO. IF THIS APPOINTMENT CITY ZIP STATE **EMPLOYER NAME** IS FOR YOU HOME PHONE NO. FAX START HERE INSURED'S NAME CELL **EMAIL** DATE OF BIRTH RELATIONSHIP TO PATIENT BIRTHDATE FEMALE AGE MALE INSURED'S I.D. NO. MARRIED SINGLE DIVORCED WIDOWED INSURED'S SOCIAL SECURITY NO. SOCIAL SECURITY NO. SECONDARY CARRIER INSURANCE COMPANY DATE LAST NAME FIRST M.I. GROUP NO. ADDRESS **EMPLOYER NAME IFTHIS** APPOINTMENT IS CITY ZIP INSURED'S NAME STATE FOR YOUR CHILD START HERE HOME PHONE NO. DATE OF BIRTH RELATIONSHIP TO PATIENT BIRTHDATE AGE MALE FEMALE INSURED'S I.D. NO. INSURED'S SOCIAL SECURITY NO. SCHOOL GRADE SOCIAL SECURITY NO. IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO **ACCOUNT INFORMATION** PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT NAME RELATIONSHIP TO PATIENT SOCIAL SECURITY NO. 3 **GETTING TO KNOW YOU** ADDRESS IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT CITY STATE ZIP AT OUR OFFICE? NAME: RELATIONSHIP: PHONE NO. YOU WERE REFERRED TO US BY YOU YOUR FORMER ADDRESS NAME CITY STATE ZIP OCCUPATION PERSON TO CONTACT FOR EMERGENCY EMPLOYER'S NAME **ADDRESS** CITY PHONE NUMBER PHONE NO. FAX NO. **ADDRESS** YOUR SPOUSE CITY STATE ZIP NAME **CLOSEST RELATIVE NOT LIVING WITH YOU** OCCUPATION PHONE NUMBER EMPLOYER'S NAME

CITY

FAX NO.

ADDRESS

CITY

STATE

ZIP

ADDRESS

PHONE NO.

Patient Name	DENTAL HISTORY
atient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.

All information is completely confidential.

What was done at your last dental visit?					
Previous Dentist's Name			State Zip _		
How often do you have dental examinations? How often do you brush your teeth? Have you ever used or are currently using topical fluoride? Yes			en do you floss?		
,					
Do you have any dental problems now? Yes No					
f yes, please describe:					
Are any of your teeth sensitive to: Hot or cold? Sweets?	Yes Yes	No No	Have you ever had: Orthodontic treatment? Oral Surgery?	Yes Yes	No
Biting or Chewing? Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or	Yes Yes	No No	Periodontal treatment? Your teeth ground or the bite adjusted? A bite plate or mouth guard?	Yes Yes Yes	No No No No
any other oral lesions?	Yes	No	A serious injury to the mouth or head? If so, please describe, including cause	Yes	No
Do your gums bleed or hurt? Have your parents experienced gum disease or tooth loss?	Yes Yes	No No	Have you experienced:		
Have you noticed any loose teeth or change in your bite?	Yes	No	Clicking or popping of the jaw? Pain? (joint, ear, side of face)	Yes Yes	No No
Does food tend to become caught in between your teeth? If yes, where?	Yes	No	Difficulty in opening or closing the mouth? Difficulty in chewing on either side of the mouth? Headaches, neckaches or shoulder aches?	Yes Yes Yes	No No No
Do you:			Sore muscles (neck, shoulders)?	Yes	No
Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly? Hold foreign objects with your teeth?	Yes Yes	No No	Are you satisfied with your teeth's appearance? Would you like to keep all of your teeth all of your life?	Yes Yes	No No
(pencils, pipe, pins, nails, fingernails) Mouth breathe while awake or asleep? Have tired jaws, especially in the morning?	Yes Yes Yes	No No No	Do you feel nervous about having dental treatment? If so, what is your biggest concern?	Yes	No
Snore or have any other sleeping disorders? Smoke/chew tobacco or use other tobacco products?	Yes Yes	No No	Have you ever had an upsetting dental experience? If yes, please describe	Yes	No

(Please complete other side)

Patien	it Name					M	EDICAL	HIST	ORY
atien	t Account No.		Medical Alert						
1,	Physician's Name Have you had any medical care within t Describe	the past two years?)			 Yes	No
2.	Have you taken any medication or drug	is during the past two years	3?					- ., Yes	No
3.									No
4.	Have you ever taken prescription medic	cations for weight loss (diet	pills)?					Yes	No
	If yes, did you take any of the following			ondim			Other		
	If yes to any of the above, did you have								No
5.	Have you ever taken bone loss preventi					-			No
6.	Are you aware of having an allergic (or all figures), please specify							Yes -	No
7. 8.	Have you been a patient in the hospital Indicate which of the following you have							Yes	No
	Heart (Surgery, Disease, Attack) Yes	·		Yes	No		C (circle)	Von	No
	Chest Pain Yes			Yes	No	Hepatitis A B Venereal Disease			No No
	Congenital Heart Disease Yes		3		No	A.I.D.S./H.I.V. Po			No
	Heart Murmur Yes	No Glaucoma		Yes	No	Cold Sores/Feve			No
	High/Low Blood Pressure Yes	No Contact lenses		Yes	No	Blood Transfusio			No
	Mitral Valve Prolapse Yes	No Emphysema		Yes	No	Hemophilia		Yes	No
	Artificial Heart Valve/Pacemaker Yes	No Chronic Cough		Yes	No	Sickle Cell Disea	se	Yes	No
	Rheumatic Fever Yes	No Tuberculosis		Yes	No	Bruise Easily		Yes	No
	Arthritis/Rheumatism Yes	No Asthma		Yes	No	Liver Disease/Yel			No
	Cortisone Medicine Yes	No Hay Fever/Allergy		Yes	No	Neurological Disc			No
	Swollen Ankles	No Latex Sensitivity		Yes	No	Epilepsy or Seizu			No
	Stroke Yes	No Sinus Trouble		Yes	No	Fainting or Dizzy	•		No
	Diet (Special/Restricted)	No Radiation Therapy No Chemotherapy	y		No No	Nervous/Anxious Psychiatric/Psycl			No No
	Kidney Trouble Yes		***************************************			rsycmatic/rsyci	iological Cale	165	NO
9.	Have you lost or gained more than 10 po	ounds in the past year?			********			, Yes	No
	Do you have or have you had any diseas	•	ot listed?					. Yes	No
11	If yes, please list:	u could be pregnant? V	Yas Mar	nthe	No	Murcina	2 Vos N	-	
	Do you use birth control prescriptions?								No
a:	understand the above informatio nswered all questions to the besi sk the respective health care pro ny change in my health or medic	t of my knowledge. Sh vider or agency, who	nould further in	nform	ation b	e needed, you	have my p	ermissi	on to
			1			Date _			
His	story Review								
									.
									:]
De	ntist Signature					Date _			

GRANT D. HENSLEY, D.D.S. FAMILY & RESTORATIVE DENTISTRY

PATIENT CONSENT

Clinical

- 1. I authorize **Grant D. Hensley** to perform all recommended treatment.
- 2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other health professionals.
 - 3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

- 4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
- 5. A \$75 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

Insurance

- 6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
- 7. I authorize the Practice to submit claims for payment for services rendered or preauthorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Signature:	Date:	
Patient's Address: _		

Hensley Dental Practice, PLLC

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of **Grant D. Hensley.** I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print N	Name Address
Signat	Ture Date
Please	e check your preferred means of communication:
	You may contact me at my home telephone number
	You may contact me on my mobile telephone number
	You may contact me on my work telephone number
	You may send me an email at:
	Other
	list authorized persons with whom we may discuss your Protected Health Information (PHI) ion to custodial parents and legal guardians:
1	
	Date Added / Removed:
2	Date Added / Removed:
2 3	Date Added / Removed:
2 3 4	Date Added / Removed:
2 3 4	Date Added / Removed:
2 3 4	
2 3 4 5	
2 3 4 5	
2 3 4	Date Added / Removed: Pare Added / Removed: Date Added / Removed: Individual refused to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign