New Patient Registration and Health History

Thank you for choosing Greenhaven Family Dental as your dental care provider. Our office is committed to providing you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Today's Date: _____

Preferred Name: _____ Date of Birth: _____/_____/_____
Social Security Number: _____ Male / Female
Address: _____ Marital Status: ___Single ____ Married ____Divorced
City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Who may we thank for referring you to our office? _____

Telephone

Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____
How would you like to receive your reminders? (circle all that apply)

Phone E-Mail Text **Mobile Carrier: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Date of Birth: _____/_____/_____
City: _____ State: _____ Zip: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

Insurance Information (If you have provided us with your insurance card(s), you may skip this section.)

Primary Insurance	**Secondary Insurance**
Name of Insurance Co.: _____	Name of Insurance Co.: _____
Plan/I.D. #: _____	Plan/I.D. #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____/_____/_____	Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's SSN: _____	Policy Holder's SSN: _____
Policy Holder's Employer: _____	Policy Holder's Employer: _____

OVER

Consent for Use and Disclosure of Health Information

The following release will allow us to share pertinent information regarding your care to enhance your treatment and/or financial reimbursement for services received:

1. I authorize Greenhaven Family Dental to share information regarding my course of treatment and the services received with my medical and dental providers in order to enhance my continuing treatment and care.
2. I authorize Greenhaven Family Dental and/or any other provider or supplier of services in this office to release any information required to secure payment for services received or the payment of benefits on my behalf. I authorize the use of the signature on all insurance submissions.
3. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or on behalf of my dependents.
4. I acknowledge I have received a copy of this office's Notice of Privacy Practices.
5. I authorize Greenhaven Family Dental to use my cell phone number to call regarding appointments, treatment, insurance and my account.

X _____

Signature of Patient or parent/guardian if minor Date

Who can we share your information with?

Authorization to Disclose Protected Health Information

I authorize Greenhaven Family Dental to provide information as requested by the individual(s) below:

Name: _____

If you want to limit the information discussed, specify here: _____

_____

Name: _____

If you want to limit the information discussed, specify here: _____

_____

As stated in Greenhaven Family Dental's Notice of Privacy Practices, this authorization may be revoked at any time except to the extent that Greenhaven Family Dental has taken action in reliance upon this authorization. Revocation must be made in writing to: Greenhaven Family Dental, 13495 Elder Drive, Suite 100, Baxter, MN 56425.

X _____

Signature of Patient or parent/guardian if minor Date

Health History

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Dental History

1. Name of your last dentist:
2. Date of your last cleaning:
3. What texture brush do you use?
   ___ Soft ___Medium ____ Hard
4. Do your gums bleed while brushing? ..... Y N
5. Do your gums bleed while flossing? ..... Y N
6. Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids? ..... Y N
7. Have you noticed any loosening of your teeth?..... Y N
8. Does food tend to become caught between your teeth? ..... Y N
9. Do you have any sores or lumps in or near your mouth? ..... Y N
10. Have you experienced any of the following?
    a. Clicking? ..... Y N
    b. Pain (joint, ear, side of face)? ..... Y N
    c. Difficulty in opening or closing? ..... Y N
    d. Difficulty chewing or swallowing? ..... Y N
11. Have you ever been diagnosed with TMJ/TMD? ..... Y N
    If so, when? _____
12. Do you snore? ..... Y N
13. Have you ever had a sleep study? ..... Y N
14. Do you use a CPAP? ..... Y N
15. Have you had any head/neck/jaw injuries? ..... Y N
16. Do you have frequent headaches? ..... Y N
17. Do you clench or grind your teeth while awake or asleep? ..... Y N
18. Have you or do you have a night guard? ..... Y N
19. Have you ever had:
    a. Orthodontic Treatment (braces)? ..... Y N
    b. Oral Surgery? ..... Y N
    c. Gum/Periodontal Treatment?..... Y N
20. Do you currently have a denture or partial? ..... Y N
21. Are you satisfied with the appearance of your teeth? ..... Y N
22. Have you ever had an upsetting experience in the dental office? ..... Y N

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dental care that you will be receiving. Thank you for answering the following questions:

1. Are you in good health? ..... Y N
2. Have there been any changes in your general health in the past year? ..... Y N
3. Date of your last Physical Exam:
4. Physician's Name:
   _____
   Clinic/Office Name:
   _____
   Phone Number: _____
5. Are you now under a physician's care? ..... Y N
6. Have you ever been hospitalized for any surgical operation or serious illness? ..... Y N
7. Have you ever taken Fen-Phen/Redux? ..... Y N
8. Have you had any abnormal bleeding? ..... Y N
9. Do you bruise easily? ..... Y N
10. Have you ever required a blood transfusion? Y N
11. Do you have a persistent cough or throat clearing? ..... Y N
12. Do you use tobacco (smoking, snuff, chew)? ..... Y N
    Packs/day? _____
13. Do you drink alcoholic beverages? ..... Y N
14. Do you use drugs or other substances for recreational purposes? ..... Y N
15. Are you taking any medication(s) including Vitamins, supplements, and non-Prescription medicine? ..... Y N
    Please list: _____
    _____
    _____
    _____
    _____
    _____
16. Pharmacy Name:
    _____

Women Only:

1. Are you or do you think you may be pregnant? ..... Y N
2. Are you nursing? ..... Y N
3. Are you taking oral contraceptives? ..... Y N

OVER

Medical History Continued

Are you allergic to or have you had reactions to:

1. Local anesthetics like Novocaine?	Y	N
2. Penicillin or other antibiotics?	Y	N
3. Sulfa drugs?	Y	N
4. Barbiturates, sedatives, sleeping pills?	Y	N
5. Aspirin?	Y	N
6. Metals?	Y	N
7. Latex?	Y	N
8. Codeine?	Y	N
9. Foods? _____		
_____		
10. Other?_____		
_____		
Anaphalyctic Reaction: Do you carry an epi-pen?	Y	N

Do you have or have you ever had the following:

1. Infective Endocarditis?*	Y	N
2. Any type of stents?*	Y	N
3. Any type of transplant?*	Y	N
4. Artificial joint replacement, screws, pins, plates?*	Y	N
5. Prosthetic cardiac valve?*	Y	N
6. Cardiac valve repair?*	Y	N
7. Congenital Heart Disease (CHD)?*	Y	N
8. Cardiac transplantation?*	Y	N
9. Intravascular Access Device?*	Y	N
10. Rheumatic heart disease or Rheumatic fever?	Y	N
11. Scarlet fever?	Y	N
12. Heart defect, heart murmur or mitral valve prolapse?	Y	N
13. Congestive heart failure?	Y	N
14. Heart trouble, heart attack, or angina?	Y	N
15. Pacemaker?	Y	N
16. Heart surgery?	Y	N
17. Emphysema?	Y	N
18. High Cholesterol?	Y	N
19. Stroke?	Y	N
20. High blood pressure?	Y	N
21. Low blood pressure?	Y	N
22. Nasal obstruction?	Y	N
23. Cold sores?	Y	N
24. Steroid treatment?	Y	N
25. Hearing loss?	Y	N
26. Hepatitis, jaundice, or liver disease?	Y	N
27. Orthopnea (shortness of breath while Supine)?	Y	N
28. Sinus trouble?	Y	N
29. Lung or breathing problems?	Y	N
30. Asthma or hay fever?	Y	N
31. Hives or skin rash?	Y	N
32. Fainting spells or seizures?	Y	N
33. Leukemia?	Y	N
34. Cancer?	Y	N
35. Radiation therapy/Chemotherapy?	Y	N
36. Thyroid problems?	Y	N
37. Arthritis or rheumatism?	Y	N
38. Stomach ulcer?	Y	N
39. Kidney trouble?	Y	N
40. Tuberculosis?	Y	N
41. AIDS or HIV infection?	Y	N
42. Sexually Transmitted Disease (STD)?	Y	N
43. Epilepsy?	Y	N
44. Anemia?	Y	N
44. Diabetes?	Y	N
46. Glaucoma?	Y	N
47. Acid reflux/persistent heartburn?	Y	N
48. Psychiatric treatment?	Y	N
49. Autism?	Y	N
50. ADD/ADHD?	Y	N
51. Fibromyalga?	Y	N
52. GERD?	Y	N
53. Gout?	Y	N
54. Multiple Sclerosis (MS)?	Y	N
55. Eating disorder?	Y	N
56. Chronic fatigue?	Y	N
57. Hemophilia?	Y	N

Do you have any disease, condition, or problem not listed above that you think we should know of? _____

_____

_____

*Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y N

If yes, what antibiotic and dose_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____

Signature of Patient or parent/guardian if minor Date