Patient Registration

The following confidential information is important for us to know in planning your dental care.
Please answer each question completely. Thank You.

Patient Name	**Preferred Name**	**Date of Birth**	**Age**
Address	**City**	**State**	**Zip**
Home Phone Number	**Cell Phone Number**	**Email Address**	**Social Security Number**
Employer	**Work Phone Number**	**Your Position**	
Employer's Address	**City**	**State**	**Zip**
If Student, Name of School or College	**Male or Female**		
Person to Contact in Case of Emergency	**Home Phone Number**	**Cell Phone Number**	

Account Information

Please complete this section only if different from above

Name of Person Responsible for this Account			
Address	**City**	**State**	**Zip**
Employer	**Work Phone Number**	**Relationship to Patient**	
Employer's Address	**City**	**State**	**Zip**

Referral Information

How did you learn of our dental office? (Please Circle One)

Saw Office Sign ***South of the River Yellow Pages*** ***Website*** ***Mailing***

Referral from Friend / Relative Name ______________________________

Advertisement (Specify) ______________________________

Other ______________________________

Payment Information

I authorize payment of my dental benefits directly to Cliff Lake Dental Care and take full responsibility for all costs of my (or my child's) dental treatment. I understand and agree that all charges incurred are my responsibility, all estimated portions are expected at time of service, dental benefits that are not paid after 60 days become my responsibility, and an interest rate of 1.5% per month will be added to accounts over 60 days. I also understand and agree that I will pay all reasonable legal fees, court costs and a fee of 35% of my total bill for collection cost related to collecting overdue amounts.

Patient or Guardian Signature ____ Date _____________________

Privacy Act

By signing this form, I consent to Cliff Lake Dental Care's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. (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 disclosures 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 have the right to revoke this Consent at any time by giving us written notice of your revocation. 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 treat you or to continue treating you if you revoke this Consent.)

By signing this form, I authorize Dr. Rauchwarter to perform diagnostic procedures and treatment as may be necessary for proper dental care and I grant Dr. Rauchwarter permission for the use of photographs and records made in the process of examination to be used for purposes of research, education, or publication in a professional journal. And, by signing this form, I attest to the accuracy of all information on this Registration Form and the Health History form and I understand it is my responsibility to update this information as it changes.

Patient or Guardian Signature ____ Date _____________________

You are entitled to a copy of this form after you sign it.

Health History

The following confidential information is important for us to know in planning your dental care. Please answer each questions completely. Thank You.

Name ________________________

1. Your last physical examination was on:

____

2. Name, address, phone no. of physician:

____

____

____

3. Are you currently under the care of a physician? ☐YES ☐NO

4. Do you have or have you had any of the following conditions?

YES	NO	
☐	☐	Rheumatic fever, Rheumatic heart disease
☐	☐	Heart murmur
☐	☐	Infective endocarditis
☐	☐	Mitral valve prolapse
☐	☐	Pacemaker
☐	☐	Prosthetic heart valve
☐	☐	Heart transplant
☐	☐	Orthopedic pins, rods, screws
☐	☐	Joint replacements
☐	☐	Prosthetic devices or implants: Type:____________
☐	☐	Hemophilia, other bleeding disorders
☐	☐	Liver transplant
☐	☐	Other transplant
☐	☐	Congenital heart defect
☐	☐	Vascular disease
☐	☐	Heart surgery /Angioplasty
☐	☐	Vascular surgery
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Heart attack (Heart trouble)
☐	☐	Angina
☐	☐	Other cardiovascular disease Describe: ________________
☐	☐	Thyroid problem
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Hay fever
☐	☐	Hives or skin rash
☐	☐	Arthritis, Rheumatism
☐	☐	Anemia
☐	☐	Leukemia

YES	NO	
☐	☐	Tuberculosis
☐	☐	HIV-Infection or HIV positive
☐	☐	AIDS
☐	☐	Venereal disease
☐	☐	Stomach ulcers
☐	☐	Glaucoma
☐	☐	Chemical dependency
☐	☐	Mental health care
☐	☐	Liver disease
☐	☐	Hepatitis
☐	☐	Diabetes
☐	☐	Kidney trouble, dialysis
☐	☐	Chest pain upon exertion?
☐	☐	Shortness of breath after exercise?
☐	☐	Ankle swelling?
☐	☐	Fainting spells or seizures?
☐	☐	Dry mouth much of the time?
☐	☐	White lesions in the mouth?
☐	☐	Lumps or tumors in the mouth or neck?
☐	☐	Unusual weight loss?
☐	☐	Night sweats?
☐	☐	Diarrhea, nausea, vomiting?
☐	☐	Persistent cough, or cough up blood?
☐	☐	Cancer? Type________________

5. Have you had any of the following?

☐	☐	Abnormal bleeding (after surgery, etc?)
☐	☐	Radiation or Chemotherapy?
☐	☐	Blood transfusion (Yr______)

6. Are you allergic to, or have you had any reaction to:

☐	☐	Local anesthetic (novicaine)?
☐	☐	Penicillin, or other antibiotics?
☐	☐	Sulfa drugs?
☐	☐	Barbiturates, sedatives, or sleeping pills?
☐	☐	Aspirin, or other pain medications?
☐	☐	Iodine?
☐	☐	Other? ________________

7. Have you been hospitalized for any surgical operation or serious illness? If so, please describe.

____

____

8. Do you have a disease, condition or problem not listed above?

____

____

9. Have you ever taken any prescription weight loss medication? ☐YES ☐NO

10. Please list all prescription medications you are currently taking:

____

____

____

____

11. Please list any vitamins, mineral, herbal or other health supplements you are currently taking:

____

____

____

____

12. Women

YES	NO	
☐	☐	Are you taking contraceptives?
☐	☐	Are you pregnant?
☐	☐	Are you presently nursing?

13. Do you consume the following?

☐	☐	Tobacco ______ Per Day

Health History

The following confidential information is important for us to know in planning your dental care. Please answer each questions completely. Thank You.

☐ ☐ Soda
______ Per Day

☐ ☐ Creamer/Sugar in Coffee
______ Per Day

☐ ☐ Juice/Sports/Energy Drink
______ Per Day

☐ ☐ Mints/Gum/Hard Candy
______ Per Day

☐ ☐ Crackers/Cookies/Chips
______ Per Day