Patient Registration

Name_____ _____Birthdate_____Age_____
Last *First*
Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Circle preferred method for confirming appointments:

Home Work Cell Email Text (**If** text circle provider)… AT&T Verizon Sprint T-Mobile US Cellular

Whom may we thank for this referral?_____

Emergency Contact…Name & Phone Number_____

Spouse's Name or Parent (if a minor)_____

Primary Dental Insurance_____

Secondary Dental Insurance_____

Employer_____ Occupation_____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Mark J. Andrews, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.
Mark J. Andrews, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

_____ _____
Print Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Consent for Dental Care

I ***authorize*** Dr. Mark J. Andrews to take any necessary x-rays, photographs and study models deemed necessary to make a thorough diagnosis and release any necessary dental records to individuals involved in my dental care. Upon diagnosis, I ***authorize*** doctor to perform all recommended treatment mutually agreed upon by me. I ***consent*** to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

I ***authorize*** insurance payments to be made directly to Dr. Mark J. Andrews. I understand that I am responsible for any unpaid balance.

_____ _____
Print Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Name_____ _____ **DOB**_____ **Age** _____
Last *First*

Medical History…do you have or have you ever had any of the following?

- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Blood Disorder Type_____
- ☐ Cancer Type_____
- ☐ Headaches
- ☐ Stroke(s)
- ☐ High/Low Blood Pressure
- ☐ Heart Conditions Type_____
- ☐ Heart Valve Replacement Date_____
- ☐ Pacemaker Type & Date_____
- ☐ Hepatitis Type_____
- ☐ Diabetes Type_____
- ☐ Herpes Simplex… Type _____
- ☐ HPV (Human Papillomavirus)
- ☐ HPV Vaccination
- ☐ Pregnant
- ☐ Nursing
- ☐ Taking Hormones
- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Epilepsy, Fainting, Seizures
- ☐ Sjogren's
- ☐ Thyroid Problem
- ☐ Asthma
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Depression
- ☐ Acid Reflux/GERD
- ☐ Eating Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Surgery(s)
- ☐ Excessive Bleeding/Bruising
- ☐ Sleep Apnea/Disorder Treatment_____
- ☐ Artificial Joint or Heart Valve Replacement… Type and Date_____
  _____
  _____
- ☐ Allergy to Anesthetics
- ☐ Allergy to Latex/Rubber
- ☐ Allergy to Metals
- ☐ Allergy to Fluoride
- ☐ Allergy to Medication(s) Please list…
  _____
  _____
  _____
- ☐ Alcohol Use Frequency_____
- ☐ E-Cig/Vaping/Tobacco/ Marijuana…Type & Frequency
  _____

Do you need Pre-medication with an antibiotic prior to your dental visit? Yes or No

Please list all current prescription and over-the-counter medications and supplements…_____
_____

Are there any other medical conditions that may possibly affect your dental treatment? Yes or No **If** yes please describe _____
_____

Physician's Name and Phone Number_____

Dental History…do you have or have you ever had any of the following?

- ☐ Cold Sores/Blisters
- ☐ Canker Sores/Ulcerations
- ☐ Swelling or Lump(s) in Mouth
- ☐ Oral Cancer... Type & Date _____
- ☐ Dry Mouth
- ☐ Periodontal Treatment...Type & Date _____
  _____
- ☐ Bleeding Gums
- ☐ Wisdom Teeth Removed
- ☐ Orthodontics
- ☐ Clenching/Grinding
- ☐ Dental Implant(s)… Date_____
  _____
- ☐ Removable Appliance… Denture, Partial, Nightguard, Retainer, Sleep Apnea

Are you experiencing any dental discomfort? Yes or No **If** yes please describe?_____

Are you fearful of dental treatment? Yes or No **If** yes please describe?_____

Please list any other comments or concerns _____

Signature_____ **Date**_____