PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

TODAY'S DATE:		
LAST NAME	FIRST	M.I
PREFERRED NAME		☐ SINGLE ☐ MARRIED ☐ OTHER ☐ WIDOWED ☐ DIVORCED
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	CELL NO.	
EMAIL		
We confirm via email, text and phone calls. Please check the acceptable forms of confirmation/communication and circle your preference.	☐ E-mail ☐ Text messaging ☐ Phone call at home	☐ Phone call at work ☐ Phone call on cell
☐ MALE ☐ FEMALE	DATE OF BIRTH	SOCIAL SECURITY NO.
EMERGENCY CONTACT	RELATIONSHIP	PHONE NO.
OCCUPATION	WORK NO.	
Whom may we thank for referring you to our office?		

ACCOUNT INFORMATION

RESPONSIBLE PARTY NAME		RELATIONSHIP TO PATIENT
DRIVER'S LICENSE NO.	SOCIAL SECURITY NO.	BIRTHDATE
MAILING ADDRESS		
CITY	STATE	ZIP

DENTAL BENEFITS

Primary Benefit Carrier

INSURANCE COMPANY	PHONE NO.
PRIMARY SUBSCRIBER NAME	DATE OF BIRTH
SUBSCRIBER ID/SOCIAL SECURITY NO.	GROUP NO.
SUBSCRIBER EMPLOYER	

Secondary Benefit Carrier

INSURANCE COMPANY	PHONE NO.
PRIMARY SUBSCRIBER NAME	DATE OF BIRTH
SUBSCRIBER ID/SOCIAL SECURITY NO.	GROUP NO.
SUBSCRIBER EMPLOYER	

JOHN A. FERULLO, D.D.S, M.S., YOUR DOWNTOWN DENTIST

DENTAL HISTORY

Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item

Do you require pre-medication prior to dental treatment?	YES	NO	Are your teeth sensitive to hot, cold, sweets or pressure?	YES	NO
Do your gums bleed when you brush?	YES	NO	History of sleep apnea?	YES	NO
Do you grind or clench your teeth?	YES	NO	Do you have problems with your jaw joint?	YES	NO
Do you have or is there anyone in your family with a history of periodontal disease?	YES	NO	Have you ever had trouble getting numb or had a reaction to anesthetic?	YES	NO

How can we make your dental experience more comfortable?

How do you feel about your smile?

Previous Dentist	Date of last dental visit

What is your immediate concern?

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years?

Physician Name	Physician phone
Please list any medications you are currently taking	Please list any medications or substances that have caused you to have an adverse or allergic reaction
FOR WOMEN ONLY Are you: Pregnant? YES NO Number of weeks ___ Nursing? YES NO Birth control pills or hormonal replacement? YES NO	Are you taking or scheduled to begin taking any type of bone density medication such as Fosamax®, Zometa®, or Boniva? YES NO

Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item

When climbing stairs or taking long walks, does chest pain, shortness of breath or exhaustion force you to stop?	YES	NO
Have you lost or gained more than 10 pounds in the last year?	YES	NO
Do you ever wake up from sleep and feel short of breath?	YES	NO

Heart Failure	YES	NO	Smoke or use Tobacco	YES	NO	Hepatitis A (Infectious)	YES	NO
Heart Disease or Attack	YES	NO	Stroke	YES	NO	Hepatitis B or C (serum)	YES	NO
Angina Pectoris	YES	NO	Artificial Joints	YES	NO	Sexually transmitted disease	YES	NO
Congenital Heart Disease	YES	NO	Kidney Trouble	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Ulcers	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Diabetes	YES	NO	Cold Sores/Fever Blisters	YES	NO
Low Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Blood Transfusions	YES	NO
Cancer	YES	NO	Glaucoma	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Arthritis/Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO

Do you have or have had any condition not listed? YES NO please explain if yes

CONSENT: The undersigned herby authorizes Dr. John A. Ferullo to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. John A. Ferullo to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Patient name)____ and further authorize and consent that Dr. John A. Ferullo choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility of payment for Dental Services provided in this office for myself or my dependents is a 1 ½ % finance charge (18% annually) will be added to my balance over 60 days. In the event of default, I (we) promise to pay legal interest in the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect condition of this note.

Patient ____**Date** ___________________ **Witness** ____

Parent or Responsible Party ____ **Relationship to Patient** ______________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. ****You May Refuse to Sign This Acknowledgement****

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of John A. Ferullo, DDS, MS.

Print Name: ____

Sign: ____

Date: ______________________________

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, _________________________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation, it was not possible to obtain an acknowledgement
- We weren’t able to communicate with the patient
- Other (please provide specific details)____