Turner Dental Group

PATIENT REGISTRATION

PLEASE PROVIDE INSURANCE CARDS TO RECEPTIONIST BEFORE APPOINTMENT

Todays Date: _____

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

Address: _____ Preferred Name: _____

City, State, Zip _____ E-Mail: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Employment Status: Full Time Part Time Retired

Employer: _____

Student Status: Full Time Part Time

School: _____

Emergency Contact: _____

Emergency Contact #: _____

Who referred you? _____ How Long Since Last Visit? _____

Reason for today's visit? _____

Responsible Party (*if someone other than patient*):

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

Address: _____ Preferred Name: _____

City, State, Zip _____ E-Mail: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Primary Care Physician: _____ Telephone: _____

Last Visit: _____

Blood Thinners: yes _____ no _____

Name of blood thinner: _____

Date Last Taken: _____

We are required by law to have our patients update registration & medical history every 12 months even if there are no changes.

Turner Dental Group

Date 5/30/2017

Medical History 2017(Copy)

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No	If yes	
Do you use tobacco?	○ Yes ○ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances? ○ Yes ○ No If yes

Do you have, or have you HAD, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Chest Pains
☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths	☐ Congenital Heart Disorder
☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers	☐ Convulsions
☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X

Date:_____

Turner Dental Group
2933 S. 47th Street
Kansas City, KS 66106
Phone 913-677-1004
Fax 913-677-2820

Consent for use and disclosure of health information

PATIENT GIVING CONSENT

Patient name_____

Address _____

Telephone_____E-mail:_____

TO THE PATIENT- **Please read the following statements carefully**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 out 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 we maintain.

You may obtain a copy of our Notice of Privacy Practices , including any revisions of our Notice, at any time by contacting Carolee Dorsey at 913.677.1004 or by fax at 913.677.2820 or by E-mail at turnerdentist@gmail.com or in writing at 2933 S. 47th Street, Kansas City, KS 66106.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: _____ Date:_____

If this Consent is signed by someone other than the patient, please complete the following:

Relationship to patient: _____