NEW PATIENT REGISTRATION

Today's Date_____/_____/_____

Patient name____ NICKNAME: __________________

SS#_______-_______-_______ Birthdate _______/_______/_______ Age _______

If Minor: Mom:______________________________________ Phone #____

Dad: :______________________________________ Phone #____

Address ____ City___________________State _______ Zip ______________

Home Phone (________) _________-_____________ Work Phone (________) __________-___________

Cell (______) ______-__________ TEXT YES NO

EMAIL:____

Occupation ____ Employer____

Circle One: Single Married Separated Divorced Widowed Student at _______________________________

Physician's Name_________________________________ Dentist's Name______________________________________

Whom May We Thank For This Referral____

Emergency Contact:___________________________________ Relationship to Patient_________________

Home/Work Phone(______) _______-______________ Mobile Phone(______) _______-______________

DENTAL INSURANCE : We will copy your insurance card.

RELEASE

I authorize Dr. Boltchi to perform diagnostic procedures and treatment as may be necessary for proper care. I authorize release of any information concerning my (or my child's) health/dental care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and the payment of insurance benefits directly to the doctor, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Boltchi or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature____ DATE _____/_____/________
(Parent or Guardian)
(revised 2013)

MEDICAL HISTORY

GETTING TO KNOW YOU BETTER

A COMPREHENSIVE MEDICAL AND DENTAL HISTORY IS REQUIRED FOR AN ACCURATE DIAGNOSIS AND THE SAFE AND EFFECTIVE TREATMENT OF PERIODONTAL DISEASE.

Name________________________ Height__________ Weight__________ Age_________ Date__/__/__

DO YOU HAVE OR HAVE YOU EVER HAD:

1. Hospitalization for any illness or surgery………………….Yes No
2. An Allergic Reaction……………………………………...Yes No
3. Any Reaction to:
   a. Aspirin……………………………… Yes No
   b. penicillin, keflex…………………………… Yes No
   c. erythromycin……………………………… Yes No
   d. tetracycline…………………………… Yes No
   e. codeine, vicodin, percodan…………… Yes No
   f. sedatives or sleeping pills(barbiturates) Yes No
   g. narcotics, Demerol, morphine………………Yes No
   h. tranquilizers, valium, versed, halcion……… Yes No
   i. dental anesthetics, general anesthetics…… Yes No
   j. any other medications……………………… Yes No
4. Hepatitis………………………………………………… Yes No
5. Jaundice (yellow skin and eyes)………………… Yes No
6. Epilepsy………………………………………………. Yes No
7. Arthritis……………………………………………… Yes No
8. Venereal Disease……………………………………… Yes No
9. Rheumatic Fever……………………………………... Yes No
10. Scarlet Fever……………………………………………. Yes No
11. Anemia or other blood disorder………………………... Yes No
12. Prolonged bleeding due to slight cut………………… Yes No
13. Kidney Disease………………………………………… Yes No
14. Diabetes……………………………………………… Yes No
15. Stomach or duodenal ulcer………………………………. Yes No
16. Liver Disease……………………………………… Yes No
17. Tuberculosis…………………………………………………Yes No
18. Emphysema………………………………………………...Yes No
19. Thyroid or parathyroid disorder……………………… Yes No
20. Heart trouble of any kind…………………………… Yes No
21. Heart Murmur……………………………………… Yes No
22. Arteriosclerosis…………………………………… Yes No
23. High Blood Pressure………………………………… Yes No
24. Low Blood Pressure……………………………………. Yes No
25. Excessively Swollen Ankles……………………… Yes No
26. A Stroke……………………….………………...Yes No
27. Shortness of Breath or Mild Exertion……….…....Yes No
28. Chest Pains or Mild Exertion………………………Yes No
29. Hives, Skin Rash, Hay Fever………………………Yes No
30. Asthma…………………………………………….Yes No
31. Emotional problems or Tension……………………Yes No
32. Psychiatric Treatment……………………………..Yes No
33. A tumor or abnormal growth……………….........Yes No
34. Radiation treatment by cobalt, radium. X-ray, etc…Yes No
35. Glaucoma………………………………………….Yes No
36. Contact Lenses…………………………………….Yes No
37. Prostate Disorder…………………………...........Yes No
38. Artificial Joints or Prosthesis………………………Yes No
39. Heart or Bypass Surgery…………………….........Yes No
40. Present or past history of chemical dependency…..Yes No
41. AIDS or HIV positive……………………………...Yes No

ARE YOU:

42. Presently being treated for any illness……………..Yes No
43. Taking medications regularly or in the past year…..Yes No
44. Any Changes in your health in the past year………Yes No
45. Aware of any recent weight change………………..Yes No
46. Often Thirsty………………………………………Yes No
47. Urinating more than six times a day………………Yes No
48. Often Exhausted or fatigued……………………....Yes No
49. Subject to frequent headaches………………..…Yes No
50. A Heavy smoker (1 pack or more a day)……...…..Yes No
51. Generally a nervous person…………………..……Yes No
52. Often unhappy or depressed……………………..……Yes No
53. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for Osteoporosis Yes No

IF FEMALE, ARE YOU NOW:

54. Pregnant or possibly pregnant………………..……..Yes No
55. Taking birth control pills or other hormones..……..Yes No
56. Presently under going menopause……………..…..Yes No
57. Past Menopause…………………………………....Yes No

PLEASE EXPLAIN FULLY ANY YES ANSWERS:

____

____

____

____

Patient Signature___________________________ Doctor Signature_______________________ Date___/___/___

(revised 2013)

DENTAL HISTORY

GETTING TO KNOW YOU BETTER

DO YOU HAVE OR EVER HAD:

1. Bleeding gums………………………………Yes No
2. Tender or sore gums……………………….. Yes No
3. Loose teeth………………………………….Yes No
14. Notice your bite change……………………………Yes No
15. Head or neck injuries………………………………Yes No
16. Instructions in proper oral hygiene………………...Yes No

4. Gum abscess/boils…………………………..Yes No
5. Periodontal Disease (pyorrhea)/gum disease. Yes No
6. Gum Recession…………………………… Yes No
7. Teeth Sensitive…………………………… Yes No
8. Bad Taste or Odor in mouth……………… Yes No
9. Grinding or Clenching teeth……………… Yes No
10. Sore Jaws……………………………………Yes No
11. Jaw clicking or Popping……………………Yes No
12. Difficulty chewing…………………………. Yes No
13. Trouble opening or Closing mouth………… Yes No

17. Periodontal or Gum Treatment……………………Yes No
18. Orthodontic Treatment………..………………..……Yes No
19. Root Canal treatment (nerve removed)……………Yes No
20. Teeth grounded down or Bite adjusted…………….Yes No
21. Oral Surgery (tooth extracted)……………………..Yes No
22. Fever blisters on lips or in mouth…………………Yes No
23. Anxiety of Dental Treatment...................................Yes No
24. Excessive bleeding after dental extractions………..Yes No
25. Reaction to local anesthetic………………………...Yes No
26. Other…………………………………………………Yes No

Referred by___________________________ Your Dentist________________________________ How Long__________________
Previous Dentist_________________________ City______________________________________ How Long__________________

Please state briefly the reason for which you were referred to our office

____

____

What concerns you most about your treatment?____

Please list all current prescription and over-the-counter medications for:
Patient Name:____________________________Meds as of date:___________________________

Drug Name	For	Dosage	Prescribing Doctor

Patient signature______________________ **Doctor Signature** ______________________ **Date** ___/___/___

(revised 2013)

revised 2013)

Farhad E. Boltchi, D.M.D., M.S., P.A.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Ackowledgement

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date:______________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Other (Please Specify _____________________________________
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENT 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 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. I we ever change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the change.

SIGNATURE

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 out treatment, payment activities and health care operations. I give the following person(s) authorization to obtain information about me.

Name: ____ Relationship: ______________________
Name: ____ Relationship: ______________________
Name: ____ Relationship: ______________________
Name: ____ Relationship: ______________________

Signature:____Date: _________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's name: _____________________________________
Relationship to Patient: ____

(revised 2013)