

PATIENT REGISTRATION AND HEALTH HISTORY

ACCOUNT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE () _____ MOTHER'S WORK PHONE () _____ FATHER'S WORK PHONE () _____

FATHER'S NAME _____

FATHER'S OCCUPATION _____

SOCIAL SECURITY NUMBER _____

GROUP NUMBER _____

EMPLOYER _____

BUSINESS ADDRESS _____

BIRTHDAY _____

MOTHER'S NAME _____

Miss Mrs. Ms.

MOTHER'S OCCUPATION _____

SOCIAL SECURITY NUMBER _____

GROUP NUMBER _____

EMPLOYER _____

BUSINESS ADDRESS _____

BIRTHDAY _____

INSURANCE INFORMATION

PATIENT LAST NAME _____

FIRST NAME _____

NICKNAME _____

SOCIAL SECURITY NUMBER _____

BIRTHDAY _____

SEX M F

FAMILY DOCTOR _____

SCHOOL _____

WHO REFERRED YOU TO OUR OFFICE?

NAME _____

ADDRESS _____

PHONE NUMBER _____

CARRIER _____

CONTACT _____

DEPARTMENT _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

OVER

HEALTH HISTORY

A. DENTAL

	YES	NO
Date of last visit to a dentist? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any unhappy dental experiences	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth - teeth - head?	<input type="checkbox"/>	<input type="checkbox"/>
Thumbsucking	<input type="checkbox"/>	<input type="checkbox"/>
Fingersucking	<input type="checkbox"/>	<input type="checkbox"/>
Lip Biting	<input type="checkbox"/>	<input type="checkbox"/>
Nail Biting	<input type="checkbox"/>	<input type="checkbox"/>
Tongue Thrusting	<input type="checkbox"/>	<input type="checkbox"/>
Does your child brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child let you assist with tooth brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride taken in any form other than in toothpaste?	<input type="checkbox"/>	<input type="checkbox"/>
Child's attitude to dentist	<input type="checkbox"/>	<input type="checkbox"/>
Do you desire complete dental service for the child?	<input type="checkbox"/>	<input type="checkbox"/>
Has orthodontic treatment been recommended?	<input type="checkbox"/>	<input type="checkbox"/>

B. MEDICAL

	YES	NO
Is your child in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Comments _____		
Does your child have regular medical exams?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last exam _____		
Reason for exam _____		
Were there any problems in the birth of this child?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? and why? _____		
Has child ever experience an unfavorable or allergic reaction to drugs, including antibiotics (Penicillin) and local anethetics (Novacaine)	<input type="checkbox"/>	<input type="checkbox"/>
In the learning process, would you classify your child as:		
Above average	Average	Below average
Comments _____		

Has child any history or difficulty with any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mastoid problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Chest Congestion
<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	<input type="checkbox"/>	Malignancy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or Severe Nose Bleed
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Aids - HIV
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	Other

Family Physician or Pediatrician _____

Address _____ Phone # _____

Are other family members under care? Names _____

FINANCIAL STATEMENT:

Payment for dental treatment is expected when services are performed. We accept checks, cash, Visa or Master Card. If you have dental insurance we will be happy to file any claims, however, you are still responsible for your account. Dental insurance coverage on your child rarely covers all expenses. Obligation for payment still belongs to you. Accounts are due and payable as work progresses, regardless of insurance. Any overpayment on your account will be refunded to you when child's dental work is completed.

Any account delinquent over 30 days will be turned over to our lawyer for collection. There is a \$50.00 return check charge and any check not paid in cash on demand will be turned over to the district attorney for prosecution.

In order to make ideal dental care available to as many of our patients as possible, on more extensive cases (\$200.00 or more) we will submit a pre-determination of benefits to the insurance company.

Signature _____ Date _____

Financial Office Policy

Initial ____ A fee of \$50 per patient is charged for NO SHOW or cancelled appointments that have not been given 24 hours notice.

Initial ____ If you have dental insurance, we will file your claim and give you an approximate total for your co-payment.

Initial ____ We accept Visa, MasterCard, or Discover. Checks are no longer accepted.

Initial ____ Payment for dental treatment is due the day services are performed.

Signature _____

Date _____

Patient Privacy Questionnaire

Patient Name: _____

The following questions refer to how you want the office of Daniel E. Donohue, D.D.S to handle your correspondence regarding your confidential medical information. Please complete this form, sign and date it. Your responses will be considered durable until withdrawn. You may change your responses at any time by completing a new form. For more information please see the Notice of Privacy Policies and Practices.

1. Please list all persons whom we may inform about your medical condition or diagnosis. List all persons whom may accompany your child:

2. Please list those people that we may contact **ONLY** in case of emergency:

3. Please print the address of where you would like your billing statements and other correspondence from this office sent:

4. Please indicate if you want all correspondence from our office marked "CONFIDENTIAL"
YES _____ NO _____
5. Please provide the telephone numbers, if any, where you want to receive phone calls about appointments, test results, or other medical information

6. Can confidential messages (example: appointment reminders) be left on your home answering machine or voice mail?
YES _____ NO _____
7. May we contact your pharmacy by phone regarding prescriptions?
YES _____ NO _____
8. May we communicate pertinent confidential medical information to your other treating doctors?
YES _____ NO _____

Signature of Patient/Guardian (if under age 18)/Legal Custodian

Date

Daniel E. Donohue, D.D.S.

Acknowledgement of Receipt
Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

Please print name

Signature

Date

FOR OFFICE USE ONLY

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this acknowledgement of Receipt for the notice. I could not be obtained because:

Individual refused to sign.

Parent stated a copy was received previously prior to treatment of sibling.

Communications or language barrier

Emergency situation prevented obtaining acknowledgement.

Other (specify below).

Received by _____ Date _____

Staff Member