PATIENT REGISTRATION

FIRST NAME | LAST NAME | MI | PREFERRED NAME

PATIENT IS: ☐ Policy Holder ☐ Responsible Party

Patient Information

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

HOME PHONE | WORK PHONE | EXTENSION | MOBILE PHONE

SEX: ○ Male ○ Female MARITAL STATUS: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

mm/dd/yyyy
BIRTH DATE | SOCIAL SECURITY NUMBER | DRIVER LICENSE NUMBER

☐ I would like to receive correspondences via e-mail.

AGE | EMAIL

EMPLOYMENT STATUS: ○ Full Time ○ Part Time ○ Retired STUDENT STATUS: ○ Full Time ○ Part Time

EMPLOYER ID | CARRIER ID

PREFERRED DENTIST (If referred) | PREFERRED PHARMACY | PREFERRED HYGIENIST

EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE NUMBER

Responsible Party (If someone other than the patient)

FIRST NAME | LAST NAME | MI

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

HOME PHONE | WORK PHONE | EXTENSION | MOBILE PHONE

mm/dd/yyyy
BIRTH DATE | SOCIAL SECURITY NUMBER | DRIVER LICENSE NUMBER

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Primary Insurance Information

NAME OF INSURED | INSURED SOCIAL SECURITY NUMBER | INSURED BIRTH DATE (mm/dd/yyyy)

RELATIONSHIP TO PATIENT: ○ Self ○ Spouse ○ Child ○ Other

EMPLOYER NAME

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

INSURANCE COMPANY NAME

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

Secondary Insurance Information

NAME OF INSURED | INSURED SOCIAL SECURITY NUMBER | INSURED BIRTH DATE (mm/dd/yyyy)

RELATIONSHIP TO PATIENT: ○ Self ○ Spouse ○ Child ○ Other

EMPLOYER NAME

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

INSURANCE COMPANY NAME

ADDRESS | SUITE, APT.

CITY | STATE | ZIP

PATIENT SIGNATURE (TO BE COMPLETED IN OFFICE)

HEALTH HISTORY

Our primary goal is patient safety, and although our dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

PATIENT NAME

mm/dd/yyyy
BIRTH DATE

ARE YOU UNDER A PHYSICIAN CARE NOW? ○ Yes ○ No
IF YES, PLEASE EXPLAIN

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? ○ Yes ○ No
IF YES, PLEASE EXPLAIN

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ○ Yes ○ No
IF YES, PLEASE EXPLAIN

ARE YOU TAKING ANY PRESCRIPTION MEDICATIONS? (Please List Below) ○ Yes ○ No
IF YES, PLEASE EXPLAIN

ARE YOU TAKING ANY OVER THE COUNTER MEDICATIONS? (Please List Below) ○ Yes ○ No
IF YES, PLEASE EXPLAIN

DO YOU USE TOBACCO? CIGARETTES, CIGARS, CHEWING TOBACCO, E-CIGARETTES ○ Yes ○ No
IF YES, PLEASE EXPLAIN

DO YOU USE CONTROLLED SUBSTANCES? (INCLUDING MARIJUANA/THC) ○ Yes ○ No
IF YES, PLEASE EXPLAIN

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? ○ Yes ○ No
IF YES, PLEASE EXPLAIN

ARE YOU ON A SPECIAL DIET? ○ Yes ○ No
IF YES, PLEASE EXPLAIN

WOMEN, PLEASE CHECK ALL THAT APPLIES:

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Using oral contraceptives

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine/Hydrocodone ☐ Acrylic ☐ Metal/Nickel ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics

LIST ANY OTHER ALLERGIES

MEDICATION	**DOSE**	**FREQUENCY**

DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING?

○ Yes ○ No AIDS/HIV POSITIVE	○ Yes ○ No ALZHEIMER'S DISEASE	○ Yes ○ No ANAPHYLAXIS
○ Yes ○ No ANEMIA	○ Yes ○ No ANGINA	○ Yes ○ No ARTHRITIS
○ Yes ○ No ARTIFICIAL HEART VALVE	○ Yes ○ No ARTIFICIAL JOINT	○ Yes ○ No ASTHMA
○ Yes ○ No BLOOD DISEASE	○ Yes ○ No BLOOD TRANSFUSION	○ Yes ○ No BREATHING PROBLEMS
○ Yes ○ No BRUISE EASILY	○ Yes ○ No CANCER	○ Yes ○ No CHEMOTHERAPY
○ Yes ○ No CHEST PAINS	○ Yes ○ No CHRONIC SINUS TROUBLE	○ Yes ○ No COLD SORES/FEVER BLISTERS
○ Yes ○ No CONGENITAL HEART DISORDERS	○ Yes ○ No CONGESTIVE HEART FAILURE	○ Yes ○ No CORTISONE MEDICATION
○ Yes ○ No DIABETES - TYPE 1	○ Yes ○ No DIABETES - TYPE 2	○ Yes ○ No DRUG ADDICTION
○ Yes ○ No EASILY WINDED	○ Yes ○ No EMPHYSEMA/COPD	○ Yes ○ No EPILEPSY OR SEIZURES
○ Yes ○ No EXCESSIVE BLEEDING	○ Yes ○ No FAINTING SPELLS/DIZZINESS	○ Yes ○ No FREQUENT COUGH
○ Yes ○ No FREQUENT HEADACHES	○ Yes ○ No GASTRIC OR INTESTINAL ULCER	○ Yes ○ No GLAUCOMA
○ Yes ○ No GOUT	○ Yes ○ No HAY FEVER	○ Yes ○ No HEART ATTACK/FAILURE
○ Yes ○ No HEART DISEASE	○ Yes ○ No HEART MURMUR	○ Yes ○ No HEART PACEMAKER
○ Yes ○ No HEMOPHILIA	○ Yes ○ No HEPATITIS A	○ Yes ○ No HEPATITIS B
○ Yes ○ No HEPATITIS C	○ Yes ○ No HIGH BLOOD PRESSURE	○ Yes ○ No HIGH CHOLESTEROL
○ Yes ○ No HIVES OR RASH	○ Yes ○ No HYPOGLYCEMIA	○ Yes ○ No IRREGULAR HEARTBEAT
○ Yes ○ No KIDNEY DISEASE	○ Yes ○ No LEUKEMIA/LYMPHOMA	○ Yes ○ No LIVER DISEASE
○ Yes ○ No LOW BLOOD PRESSURE	○ Yes ○ No LUNG DISEASE	○ Yes ○ No MITRAL VALVE PROPLAPSE
○ Yes ○ No OSTEOPOROSIS/OSTEOPENIA	○ Yes ○ No PAIN IN JAW JOINTS	○ Yes ○ No PARATHYROID DISEASE
○ Yes ○ No PSYCHIATRIC CARE	○ Yes ○ No RADIATION THERAPY	○ Yes ○ No RECENT WEIGHT LOSS
○ Yes ○ No RENAL DIALYSIS	○ Yes ○ No RHEUMATIC FEVER	○ Yes ○ No RHEUMATOID SCARLET-FEVER
○ Yes ○ No SCARLET FEVER	○ Yes ○ No SHINGLES	○ Yes ○ No SICKLE CELL DISEASE
○ Yes ○ No SLEEP APNEA	○ Yes ○ No SPINA BIFIDA	○ Yes ○ No STOMACH/INTESTINAL DISEASE
○ Yes ○ No STROKE	○ Yes ○ No SWELLING OF LIMBS	○ Yes ○ No THYROID DISEASE
○ Yes ○ No TIA (MINI-STROKE)	○ Yes ○ No TUBERCULOSIS	○ Yes ○ No TUMORS OF GROWTHS

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ○ Yes ○ No

IF YES, PLEASE EXPLAIN

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 MY MEDICAL STATUS OF MEDICATIONS.

mm/dd/yyyy

DATE

PATIENT SIGNATURE (TO BE COMPLETED IN OFFICE)

RELEASE FORM

PATIENT NAME

Welcome to our practice. We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best possible dental care for our patients.

Please read the following statements. **The patient or legal guardian must agree and sign.**

General Release

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I further authorize and consent that the doctor may consult with my physician or other health care providers regarding my periodontal treatment. I also authorize the doctor to perform any form of treatment, medication, and/or therapy that may be indicated. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed.

Patient Contact

I CONSENT TO THE DAVID A. WOODRUFF, DDS, PC DENTAL PRACTICE USING MY CELL PHONE NUMBER TO:

○ Call ○ Text ○ Both

Regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

MOBILE PHONE NUMBER (PLEASE INCLUDE AREA CODE)

Financial Responsibilities

Part of our commitment to patient care is to provide you with information about your dental needs and treatment, including the estimated costs of your quality care. Our fees are individually based on the time, severity, and difficulty of your specialty treatment. **Payment not covered by your insurance is expected at the time of service.** We accept cash, check, ATM, and credit card payments. A $25.00 fee is charged an all returned checks. A 1.5% service charge will be assessed on all accounts not settled within 90 days of service.

I understand that I am responsible for any payment due for services that I have received. In addition to the portion of the services not covered by my insurance carrier, I am responsible for any outstanding balance after the insurance carrier has been estimated and/or billed. I also understand that payment not covered by my insurance is expected at the time of service. If David A. Woodruff, DDS, PC is subsequently paid by the insurance carrier I will be reimbursed.

Finally, I understand that the David A. Woodruff, DDS, PC dental practice reserves a specific time for me on their appointment schedule and that not confirming an appointment, canceling an appointment without 24-hour notice or not showing to an appointment does not allow time for that vacancy to be filled. Therefore, I am hereby notified that this office reserves the right to charge a minimum fee of $75 for any, missed appointments or those canceled without 24-hour notice. I am also notified that any appointment unconfirmed may be canceled.

RELATIONSHIP TO PATIENT (TYPE "SELF" IF IT'S FOR YOURSELF.)

mm/dd/yyyy

DATE

PATIENT SIGNATURE (TO BE COMPLETED IN OFFICE)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

View Notice of Privacy Practices

PATIENT NAME

PATIENT SIGNATURE (TO BE COMPLETED IN OFFICE)

DATE (TO BE COMPLETED IN OFFICE)

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

PLEASE LIST ADDITIONAL FAMILY MEMBERS AND OTHERS WE MAY SHARE YOUR HEALTH INFOMRATION WITH:

PATIENT VALIDATION (YOUR NAME NEEDED TO SUBMIT ONLINE FORM)