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? _____	☐	☐
Has your child complained about dental problems?	☐	☐
Have there been any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head?	☐	☐
Thumbsucking	☐	☐
Fingersucking	☐	☐
Lip Biting	☐	☐
Nail Biting	☐	☐
Tongue Thrusting	☐	☐
Does your child brush teeth daily?	☐	☐
Does your child let you assist with tooth brushing?	☐	☐
Flossing?	☐	☐
Is fluoride taken in any form other than in toothpaste?	☐	☐
Child's attitude to dentist	☐	☐
Do you desire complete dental service for the child?	☐	☐
Has orthodontic treatment been recommended?	☐	☐

B. MEDICAL	YES	NO
Is you child in good health?	☐	☐
Comments _____		
Does your child have regular medical exams?	☐	☐
Date of last exam _____		
Reason for exam _____		
Were there any problems in the birth of this child?	☐	☐
Is your child taking any medication?	☐	☐
If so, what? and why? _____		
_____		
Has child ever experience an unfavorable or allergic reaction to drugs, including antibiotics (Penicillin) and local anethetics (Novacaine)	☐	☐

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	
☐	☐	Tuberculosis	☐	☐	Anemia	☐	☐	Mastoid problems	☐	☐	Chronic Chest Congestion
☐	☐	Bladder problems	☐	☐	Chronic sinus	☐	☐	Thyroid problems	☐	☐	Cerebral Palsy
☐	☐	Epilepsy	☐	☐	Heart	☐	☐	Bedwetting	☐	☐	Hearing Problems
☐	☐	Malignancy	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Frequent or Severe Nose Bleed
☐	☐	Hepatitis	☐	☐	Asthma	☐	☐	Liver problems	☐	☐	Pregnancy
☐	☐	Bleeding Disorder	☐	☐	Convulsions or seizures	☐	☐	Mononucleosis	☐	☐	Aids - HIV
☐	☐	Fainting Spells	☐	☐	Kidney problems	☐	☐	Speech problems	☐	☐	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