LANDERHAVEN DENTAL ASSOCIATES

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DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________________

SS/HIC/Patient ID # ______________________________

Patient Name ______________________________
Last Name

____
First Name Middle Initial

Address ______________________________

E-mail ______________________________

City ______________________________

State ______________ Zip ______________

Sex ☐ M ☐ F Age ______________

Birthdate ______________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________________

Occupation ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS# ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) ______________ Work (_____) ______________ Ext _____ Cell Phone (_____) ______________

Spouse's Work (_____) ______________ Best time and place to reach you ______________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________________ Relationship ______________________________

Home Phone (_____) ______________________________ Work Phone (_____) ______________________________

WELCOME TO OUR PRACTICE!

For your health's sake, you must be accurate!

MEDICAL HISTORY

Name ______________________ Date of Birth ______________

Address ______________ City __________ Zip __________ Phone (h) __________ (w) __________

Occupation ______________ Employer ______________ S.S. No. ______________

Closest Relative ______________ Address ______________ Phone ______________

1. How would you describe your general health? ______________
2. Are you now or have you been under the care of a medical doctor during the past two years? Yes _____ No _____
3. If yes, what condition was or is currently being treated? ______________
4. Name(s) of physician(s) ______________ Date of Last Exam ______________
5. Have you ever been hospitalized or had a serious illness? .... Yes _____ No _____
   if yes, please explain ______________
6. Are you allergic to (e.g. itching, rash, swelling of hands, feet or eyes), or made sick by penicillin, aspirin, codeine, novocaine, or any other antibiotics, anesthetics, or drugs .... Yes _____ No _____
7. Circle any of the following which you have had or have at present. Please be complete.

Rheumatic Fever	Yes	No	Bleeding Disorder (e.g., prolonged bleeding, bruise easily)	Yes	No	Thyroid Disease	Yes	No
Scarlet Fever	Yes	No				Chemotherapy (Cancer, Leukemia)	Yes	No
Heart Murmur	Yes	No						
Mitral Valve Prolapse	Yes	No				Cortisone Therapy	Yes	No
Artificial Heart Valve	Yes	No	Kidney Disorders	Yes	No	Arthritis or Rheumatism	Yes	No
Artificial Joint	Yes	No	Ulcers	Yes	No	Glaucoma	Yes	No
Heart Disease or Attack	Yes	No	Tuberculosis (TB)	Yes	No	AIDS, or HIV positive	Yes	No
Angina Pectoris (Chest Pain)	Yes	No	Asthma	Yes	No	Hepatitis or Jaundice	Yes	No
			Hay Fever	Yes	No	Drug or Alcohol Abuse	Yes	No
High Blood Pressure	Yes	No	Sinus Problems	Yes	No	Venereal Disease (Syphillis, Gonorrhea, Herpes)	Yes	No
Heart Pacemaker	Yes	No	Allergies or Hives	Yes	No			
Heart Surgery	Yes	No	Emphysema	Yes	No			
Anemia	Yes	No	Bronchitis	Yes	No	Epilipsy or Seizures	Yes	No
Stroke	Yes	No	Diabetes	Yes	No	Fainting or dizzy spells	Yes	No

8. Are you in a high risk category to contract AIDS? This would include the following categories: Homosexual, Hemophiliac, Sexual Partner with AIDS, HIV positive, I.V. Drug User .... Yes _____ No _____
9. Have you had any blood transfusions? ______________ If yes; year? ______________
10. When you walk up the stairs, or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... Yes _____ No _____
11. Do your ankles swell during the day? .... Yes _____ No _____
12. Do you use more than 2 pillows to sleep? .... Yes _____ No _____
13. Are you on a special diet? .... Yes _____ No _____
14. Do you have any disease, condition or problem not listed? .... Yes _____ No _____
    If yes, please explain ______________
15. Women: Are you pregnant now? .... Yes _____ No _____
    Are you presently taking birth control pills? .... Yes _____ No _____

CURRENT MEDICATIONS

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at my next appointment.

______________________ Signature of patient, parent or guardian

______________________ Signature of dentist or hygienist

Date ______________ Date ______________

William F. Lavigna, D.D.S., Inc.

LANDERHAVEN DENTAL ASSOCIATES
William F. Lavigna D.D.S.
Joseph R. Leon D.M.D.
Patient Acknowledgement and Consent Form

Effective April 14th 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentists or health care professional, provide information to your health care insurance, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature **Patient Name (please print)**

Date

For Office Use Only
Patient Refused to Sign
The following circumstances prohibited the patient from signing the Acknowledgement:
☐ An emergency situation prevented the patient from signing the Acknowledgment.
☐ Other

Office Personnel (signature) **Office Personnel (print name)**

Date

Patient Consent

Please sign this form under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may include types not listed above.

Patient Signature **Patient Name (please print)**

Date