Patient Registration and Medical/Dental History

So that we may provide you with the best possible care, please complete and sign this medical/dental history form. (PLEASE PRINT)

Patient Information

Patient Name ________________________________ Today's Date ____________________

Email ____

Cell Phone ___________________ Home Phone ___________________ Work Phone ___________________

If you use a cell phone, may we use text messages to contact you and send you appointment reminders? ☐ Yes ☐ No

Street Address ____

City __________________ State ________ Zip ____________ Social Security # ______ - ______ - ________

Gender: ☐ Male ☐ Female Date of Birth ______ / ______ / __________ Age __________

Employer ________________________________ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Other

Emergency Contact Name ________________________ Tel.___________________ Relation ____________

Medical History

Please check the box of any condition you may have had or do have at this time.

☐ AIDS/HIV Positive
☐ Allergy to Anesthetics
☐ Allergy to Antibiotics
☐ Allergy to Latex
☐ Allergy—Hay Fever
☐ Allergy—Other/General (*List Below)
☐ Angina Pectoris
☐ Arthritis/Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joint
☐ Aspirin taken daily
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Blood Thinners (ex. Plavix)
☐ Blood Transfusion
☐ Cancer

☐ Chemical Dependency
☐ Chemotherapy/Radiation
☐ Chest Pains
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Contact Lenses
☐ Diabetes
☐ Epilepsy/Seizure Disorder
☐ Fainting/Dizziness
☐ Glaucoma
☐ Headaches
☐ Heart Disease or Attack
☐ Heart Murmur
☐ Heart Pacemaker
☐ Hemophilia
☐ Hepatitis, Jaundice
☐ High Blood Pressure
☐ High Cholesterol

☐ Hypoglycemia
☐ Implant
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pre-Medicate
☐ Psychiatric Care/Mental Disorder
☐ Recent Weight Loss
☐ Respiratory Problems
☐ Restless Leg Syndrome
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands

☐ Take Bisphosphonates (bone strengtheners)
☐ Thyroid Disease/Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcer
☐ Venereal Disease
☐ Other (*List Below)

*General Allergies ______________________
____

*Other __________________________
____

Women, are you:
Pregnant? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

Primary Care Physician's Name ___________________________ Approx. date of last exam __________________

Primary Care Physician's Street Address ____

Physician's Tel. ___________________________

Pharmacy Name ______________________________ Pharmacy Tel. __________________________

Pharmacy Address ____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ☐ Yes ☐ No

If yes, please list ____

Are you taking any medication at this time? ☐ Yes ☐ No

If yes, please list ____

____

Is there anything else we should know about your medical history? _____________________________

____

Dental History

What is the main reason(s) for your visit today? ____

Is there anything about your dental history that you would like us to know? If yes, please describe: ___________________________
____

Have you ever had an upsetting dental experience? If yes, please explain ____
____

Date of last dental visit _______________________ Have you ever been seen by Dr. Sato at a different practice? ☐ Yes ☐ No

Have you ever been told that you need a pre-medication (generally an antibiotic) before dental treatment? ☐ Yes ☐ No

Previous Dentist's Name ____ Telephone Number ___________________________

Address ____

How often do you brush your teeth? ____________________________ How often do you floss? ___________________________

Do You:

Clench or grind your teeth?	Yes / No
Have tired jaws, especially in the morning?	Yes / No
Have pain, popping or clicking in your jaw?	Yes / No
Have sore muscles in your neck and shoulders?	Yes / No

Have you ever:

Had a dentist recommend a mouth guard?	Yes / No
Had Orthodontic treatment (braces, etc.)?	Yes / No
Had oral surgery?	Yes / No
Had periodontal (gum) treatment?	Yes / No
Had a serious injury to the mouth or head?	Yes / No

Do you have:

Sensitivity to hot or cold?	Yes / No
Sensitivity to sweet foods?	Yes / No
Pain when biting/chewing?	Yes / No
Bad breath or bad tastes?	Yes / No
Bleeding gums?	Yes / No

Are you:

Overall happy with your smile?	Yes / No
Pleased with the color of your teeth?	Yes / No
Wanting to keep all of your teeth your whole life?	Yes / No
Nervous about dental treatment?	Yes / No

Billing Information

Person Financially Responsible for the Account: ☐ Patient ☐ Other (if "Other" please complete below)

Guarantor's Name: ____ Relation to patient: ____________________________

Guarantor's Date of Birth: ____________________________ Social Security # _______ - ______ - _________

Billing Address: ____

Guarantor's Phone Number: ______________________________

Dental Insurance

Insurance Company: ____ Phone Number: _________________________________

Insurance Company Address: ____

Group Number: _______________________________________ ID Number: ____

Who is the Subscriber of the policy: ☐ Patient ☐ Guarantor (listed above) ☐ Other (If "Other" please complete below)

Subscriber's Name: ____

Subscriber's Date of Birth: ____________________________ Social Security # ________ - _______ - ____________

Subscriber's Address: ____

Subscriber's Phone Number: ______________________________ Subscriber's Employer: ______________________________

Is there a secondary dental insurance? ☐ Yes ☐ No (If yes, please present the secondary card to our office staff)

Authorization and Release

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered, including services rendered on behalf of my dependents.

Signature of Patient (or Parent of Minor) ____ Date ________________________

Financial Agreement and Assignment of Benefits

I understand that services rendered to me by Steve A. Sato DDS, Inc. are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Steve A. Sato DDS, Inc. and I understand that I will be fully responsible for any outstanding balance on my account.

I also understand that should my insurance company send payment to me, I will forward the payment to Steve A. Sato DDS, Inc. within two business days. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies.

____

Signature of Patient (or Patient/Guardian)

Acknowledgement of Receipt of Notice of Privacy Practices

(Note: You may refuse to sign this acknowledgement)

I hereby acknowledge that I have been offered a copy of the written "Notice of Privacy Practices" to read in the office that Steve A. Sato DDS, Inc. follows. I understand I am also entitled to a printed copy for my records if I so desire.

____

Signature of Patient (or Patient/Guardian)

For use by Steve A. Sato DDS, Inc. personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient: I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the named patient, but was unable to for the following reason:

- *Language Barrier*
- *Patient Cannot Read*
- *Unable to Sign*
- *Read Later and Return*
- *Patient Objects*
- *Other*_______________________

___________________________________ ___________________________

Employee Name *Date*

Consent to Obtain Medication History

Our dental practice has adopted an electronic medical record system called "DoseSpot" in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you in the **last 2 years**. This list is collected from a variety of sources, including your pharmacy and your health insurer.

****An accurate medication history is very important to helping us treat you properly and** in **avoiding potentially dangerous drug interactions**.**

By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for STEVE A. SATO DDS, INC. to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

____
Signature of Patient (or Patient/Guardian)

☐ I DO NOT consent to have my medication history obtained.

Overpayment / Credit Policy

Patients can used credits towards any service for themselves or credits can be transferred to anyone they choose in the practice. Refunds for credits will be issued upon request if a patient is not in active treatment and the responsible party does not have a balance on any other contractor services with our office.

Since we advocate lifetime retention, we will keep a credit on the books for a maximum of two years after treatment to be used towards any other treatment required. Credits remaining after two years from service date will be refunded by the end of the year. Credits present that are not the result of actual cash payment (vouchers, coupons, etc.) can only be used towards payment of services rendered and will not be refunded. There is no cash value for these as no actual money was actually received and there is no monetary value outside of the practice.

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Signature of Patient (or Patient/Guardian)