

Patient Registration

The following confidential information is important for us to know in planning your dental care.
Please answer each question completely. Thank You.

Patient Name	Preferred Name	Date of Birth	Age
Address	City	State	Zip
Home Phone Number	Cell Phone Number	Email Address	Social Security Number
Employer	Work Phone Number	Your Position	
Employer's Address	City	State	Zip
If Student, Name of School or College		Male or Female	
Person to Contact in Case of Emergency	Home Phone Number	Cell Phone Number	

Account Information

Please complete this section only if different from above

Name of Person Responsible for this Account			
Address	City	State	Zip
Employer	Work Phone Number	Relationship to Patient	
Employer's Address	City	State	Zip

Referral Information

How did you learn of our dental office? (Please Check One)

Saw Office Sign	South of the River Yellow Pages	Website	Mailing
Referral from Friend / Relative Name _____			
Advertisement (Specify) _____			
Other _____			

Payment Information

I authorize payment of my dental benefits directly to Cliff Lake Dental Care and take full responsibility for all costs of my (or my child's) dental treatment. I understand and agree that all charges incurred are my responsibility, all estimated portions are expected at time of service, dental benefits that are not paid after 60 days become my responsibility, and an interest rate of 1.5% per month will be added to accounts over 60 days. I also understand and agree that I will pay all reasonable legal fees, court costs and a fee of 35% of my total bill for collection cost related to collecting overdue amounts.

Patient or Guardian Signature _____ Date _____

Privacy Act

By signing this form, I consent to Cliff Lake Dental Care's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. (You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.)

By signing this form, I authorize Dr. Rauchwarter to perform diagnostic procedures and treatment as may be necessary for proper dental care and I grant Dr. Rauchwarter permission for the use of photographs and records made in the process of examination to be used for purposes of research, education, or publication in a professional journal. And, by signing this form, I attest to the accuracy of all information on this Registration Form and the Health History form and I understand it is my responsibility to update this information as it changes.

Patient or Guardian Signature _____ Date _____

You are entitled to a copy of this form after you sign it.

Health History

The following confidential information is important for us to know in planning your dental care. Please answer each question completely. Thank You.

Name _____

1. Your last physical examination was on: _____

2. Name, address, phone no. of physician: _____

3. Are you currently under the care of a physician? Yes No

4. Do you have or have you had any of the following conditions?

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever, Rheumatic heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Infective endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic pins, rods, screws |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacements |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic devices or implants:
Type: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia, other bleeding disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | Other transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery /Angioplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack (Heart trouble) |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Other cardiovascular disease
Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever |

Yes No

- | | | |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hives or skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV-Infection or HIV positive |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health care |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble, dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain upon exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle swelling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells or seizures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth much of the time? |
| <input type="checkbox"/> | <input type="checkbox"/> | White lesions in the mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps or tumors in the mouth or neck? |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual weight loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats? |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea, nausea, vomiting? |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough, or cough up blood? |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer?
Type: _____ |

5. Have you had any of the following?

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal bleeding (after surgery, etc?) |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation or Chemotherapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion (Yr _____) |

6. Are you allergic to, or have you had any reaction to:

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetic (novocaine)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin, or other antibiotics? |

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates, sedatives, or sleeping pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin, or other pain medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other? |

7. Have you been hospitalized for any surgical operation or serious illness? If so, please describe.

8. Do you have a disease, condition or problem not listed above?

9. Have you ever taken any prescription weight loss medication? Yes No

10. Please list all prescription medications you are currently taking:

11. Please list any vitamins, mineral, herbal or other health supplements you are currently taking:

12. Women

Yes No

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking contraceptives? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently nursing? |

13. Do you consume the following?

Yes No Amount Per Day

- | | | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Soda _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Creamer/Sugar in Coffee _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Juice/Sports/Energy Drink _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mints/Gum/Hard Candy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Crackers/Cookies/Chips _____ |