

*Division Street Dental*  
**Patient Registration**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

*Responsible Party (if someone other than the patient)*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: ( ) - - Work Phone: ( ) - - Ext: \_\_\_\_\_ Cellular: ( ) -

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_

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

*Patient Information*

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: ( ) - - Work Phone: ( ) - - Ext: \_\_\_\_\_ Cellular: ( ) -

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hygienist: \_\_\_\_\_

Who Can We Thank

for Referring You?: \_\_\_\_\_

Last Dental Visit?: \_\_\_\_\_

Previous DDS: \_\_\_\_\_

Pre-med w/Antibiotic?  Yes  No

*Primary Insurance Information*

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Security: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem Deduct.: \_\_\_\_\_ .00

*Secondary Insurance Information*

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Security: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem Deduct.: \_\_\_\_\_ .00

*Division Street Dental*

**Medical History**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Although 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. Thank you for answering the following questions.

- Are you under a physician's 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 medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women? Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

**Do you have, or have you had, any of the following?**

- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No         | Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No    | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No      | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No        | Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No          | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No                | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No                    | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No   | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No            | Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No             | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No      | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No             | Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No         | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No          | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No      | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No             | Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No   | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No        | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No       | Stomach Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No          | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No              | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No               | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No         | Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No            | Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No    | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No         | Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No          | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No        | Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No               | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No      | Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No    | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No              | Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No               | Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No           | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No      | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No     | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No                | Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No    |   |
| Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No            | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No               | Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No        |   |

Have you ever had any serious illness not listed above?  Yes  No

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 medical status.

SIGNATURE OF PATIENT, PARENT, or LEGAL GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** 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 the 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 may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting one of our Front Office staff at Division Street Dental Group, 868 Auto Center Drive Suite D, Palmdale, CA 93551, (661) 945-2616.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the above entity. 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 continue treating you if you revoke this Consent.

**Print First and Last Name:**

I, \_\_\_\_\_ (or Parent/Guardian), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET.**

I, \_\_\_\_\_ (or Parent/Guardian), have received/read a copy of this office’s Notice of Privacy Practices and Dental Materials Fact Sheet.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Division Street Dental*

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you like the appearance of your teeth? Yes or No

Are your teeth as straight as you would like them to be? Yes or No

Are you happy with length, width, and shape of your teeth? Yes or No

Do you think you have a “gummy” smile? Yes or No

Do you have any missing teeth? Yes or No

Do you have any spaces between your teeth? Yes or No

Do you have any discolorations, stains or spots on your teeth? Yes or No

Do you have any dental work that you do not like? Yes or No

Do you have silver fillings that you would like changed to white? Yes or No

Do you know anyone that has any cosmetic dentistry that interests you? Yes or No

From the above questions, which concerns you most?

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If you could change anything about the appearance of your teeth, what would it be?

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