136 N. Ridge St., Suite C
Monroeville, OH 44847
(419) 465-2574
info@monroevilledental.com

PATIENT REGISTRATION

Name: _____ MI: ____ Last Name: _____
DOB: _____ Sex: ___ M ___ F
Marital Status: _____ SS#: _____ (not required for minors)
Home #: _____ Cell #: _____
Mailing Address: _____
Patient Employer: _____
Phone #:_____
Patient E-mail: _____
Referred by: _____
Hobbies: _____

INSURANCE INFORMATION

Name of Insured: _____
DOB: _____ SS#: _____
Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other: _____
Insurance Company: _____
Insurance Address: _____
Phone #: _____
Employer: _____
Phone #: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____
DOB: _____ SS#: _____
Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other: _____
Insurance Company: _____
Insurance Address: _____
Phone #: _____
Employer: _____
Phone #: _____

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RESPONSIBLE PARTY (if patient, no need to complete)

Name: _____ MI: ____ Last Name: _____
DOB: _____
Relationship to Patient: ___ Spouse ___ Parent ___ Other: _____
Address: _____
Phone #: _____
Employer: _____ Work #: _____

SPOUSE INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

PARENT INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

PARENT INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

Monroeville Dental - HEALTH HISTORY

Patient Name: Birth Date: Date Created:

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,

Are you under a physicans care now?	Yes No	If yes
Have you ever been hospitalized or had a major surgery?	Yes No	If yes
Have you ever had a serious neck or head injury?	Yes No	If yes
Do you take any medication, pills, or drugs? please list all	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	If yes

Smile Evaluation

Does the crowding or spacing of your teeth bother you?	Yes No	If yes
Are you interested in straighter, whiter smile?	Yes No	If yes
Are you unhappy with your smile?	Yes No	If yes
Is there anything you would like to change about your teeth/smile?	Yes No	If yes

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Codeine	Yes No	Acrylic	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anesthetics	Yes No

other?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant/trying	Yes No	Nursing	Yes No	Taking Oral Contraceptives	Yes No

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

AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No	Anemia	Yes No
Angina	Yes No	Arthiritis/Gout	Yes No	Artificial Heart Valve	Yes No	Artificial Joint	Yes No
Asthma	Yes No	Blood Disease	Yes No	Blood Transfusion	Yes No	Breathing Problem	Yes No
Bruises Easily	Yes No	Cancer	Yes No	Chemotherapy	Yes No	Chest Pains	Yes No
Cold Sores/Fever Blister	Yes No	Congenital Heart Disease	Yes No	Convulsions	Yes No	Cortisone Medication	Yes No
Diabetes	Yes No	Drug Addiction	Yes No	Easily Winded	Yes No	Emphysema	Yes No
Epilepsy or Seizures	Yes No	Excessive Bleeding	Yes No	Exessive thirst	Yes No	Fainting spells/Dizziness	Yes No
Frequent Cough	Yes No	Frequent Diarrhea	Yes No	Frequent Headaches	Yes No	Genital Herpes	Yes No
Glaucoma	Yes No	Hay Fever	Yes No	Heart Attack/Failure	Yes No	Heart Murmur	Yes No
Heart Pacemaker	Yes No	Heart trouble/Disease	Yes No	Hemophilia	Yes No	Hepititis A	Yes No
Hepatitis B or C	Yes No	Herpes	Yes No	High Blood pressure	Yes No	High Cholesterol	Yes No
Hives or Rash	Yes No	Hypoglycemia	Yes No	Irregular Heartbeat	Yes No	Kidney Problems	Yes No
Leukemia	Yes No	Liver Disease	Yes No	Low Blood Pressure	Yes No	Lung Disease	Yes No
Mitral Valve Prolapse	Yes No	Osteoporosis	Yes No	Pain in Jaw	Yes No	Parathyroid Disease	Yes No
Psychiatric Care	Yes No	Radiation Treatment	Yes No	Recent Weight Loss	Yes No	Renal Dialysis	Yes No
Rheumatic Fever	Yes No	Rheumatism	Yes No	Scarlet Fever	Yes No	Shingles	Yes No
Sickle Cell Disease	Yes No	Sinus trouble	Yes No	Spina Bifida	Yes No	Stomach/Intestinal Disease	Yes No
Stroke	Yes No	Swelling of Limbs	Yes No	Thyroid Disease	Yes No	Tonsillitis	Yes No
Tuberculosis	Yes No	Tumors or Growth	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

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

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 Guardian:

X Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Monroeville Dental Financial Policy

FINANCIAL POLICES: In our office, we do not want the ability to pay to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with the financial agreements regarding your dental care. We accept cash, check, Visa, MasterCard, Discover and Care Credit at the time of service.

1) **We expect copayment, deductible, and treatment plan estimate at the time of service.**
2) **A $50 return check fee for NSF.**
3) **We require 48-hour notice for appointment cancellation. A $50 cancellation fee will be charged if not given.**

Patients with Dental Insurance: I understand that my dental insurance is a contract between myself and my insurance carrier, not between Dr. Trask and the insurance carrier. I understand that I am responsible for the full amount of all dental fees incurred. I hereby authorize payment of the dental benefits be paid directly to Monroeville Dental. Any payments received by Dr. Trask from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.

Patient Name (Print): _____
Signature of Patient or Guardian: _____ Date: _____

Monroeville DENTAL

Dental Information Release form (HIPPA Release)

Name: _____ Date of Birth: _____ /_____ /_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examinations, financials, appointments, and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released.

The **Release of Information** will remain in effect until terminated in writing.

Messages

Please call ☐ my home ☐ work ☐ cell phone

If unable to reach me:

☐ You may leave a detailed message.
☐ Please leave a message asking to return call
☐ _____

The best time to reach me is _____

Signed: _____ Date: _____