PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | FAX

CELL | EMAIL

BIRTHDATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY NO.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE

LAST NAME | FIRST | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

(Please complete other side)

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
6. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ..... Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list: _____
11. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Darby & Johnson, P.A.
Periodontics & Dental Implants

John F. Darby, Jr., D.D.S.

Timothy M. Johnson, D.M.D.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Darby & Johnson, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Darby & Johnson, P.A. I understand that diagnosis or treatment of me by Darby & Johnson, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Darby & Johnson, P.A. is not required to agree to the restrictions that I may request. However, if Darby & Johnson, P.A. agrees to a restriction that I request, the restriction is binding on Darby & Johnson, P.A.

I have the right to revoke this consent in writing, at any time, except to the extent that Darby & Johnson, P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Darby & Johnson's P.A. Notice of Privacy Practices prior to signing this document. The Darby & Johnson's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Darby & Johnson, P.A. The Notice of Privacy Practices for Darby & Johnson, P.A. is also provided at the Front Desk. This Notice of Privacy Practices also describes my rights and the Darby & Johnson's duties with respect to my protected health information.

Darby & Johnson reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the Darby & Johnson's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

MEDICAL RISKS & PERIODONTAL DISEASE

3 WAYS PERIODONTAL INFECTION IS LINKED TO MEDICAL PROBLEMS

1. **BLOOD STREAM** - ***Chewing Injects Infectious Bacteria into Your Blood Stream.***
   Periodontal bacteria in the blood stream increased 4 times (24%) in those who chewed just 50 times.[1]
2. **BREATHING** - ***Periodontal Bacteria Are Breathed into Your Lungs.***
   Periodontal bacteria can be breathed into the lungs and increase the incidence of lung disease.[2]
3. **IMMUNE SYSTEM** - ***Periodontal Infection Can Lower Your Immune System.***
   A study has found that health care costs were 21% higher for those patients with severe periodontal disease.[3]

TRANSMISSION - Periodontal Infection Is Transmitted to Your Spouse & Children.
DNA tests show that periodontal infection is transmitted directly from spouse to spouse and parent to child.[4]

RESEARCH FINDINGS

ALZHEIMER'S – *DETERMINING FACTOR*
Gum disease early in life, less education, and a history of stroke are more important than genes in determining who develops dementia, concluded a study of 100 dementia patients with healthy identical twins.[5]

BLOOD CANCERS – *30% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 30% higher risk of blood cancers, including: leukemia, multiple myeloma and non-Hodgkin lymphoma.[6]

DIABETES – *INCREASED SEVERITY*
Periodontal disease affects blood sugar control, lengthens the duration of diabetic symptoms, and speeds the transition from pre-diabetes to diabetes.[7]

DIABETES – *2.8 - 3.4 TIMES MORE RISK*
Diabetic patients are 2.8 to 3.4 times more likely to have periodontal disease.[8]

HEART ATTACK – *2.7 TIMES MORE RISK*
Demographic studies of 1,372 subjects showed those with periodontal disease were 2.7 times more likely to have a heart attack.[9]

HEART DISEASE – *40–72% MORE RISK*
Demographic studies of 10,907 subjects showed a 40% to 72% increased risk of heart disease.[10]

KIDNEY CANCER – *49% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 49% higher risk of kidney cancer.[11]

LUNG CANCER – *36% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 36% higher risk of lung cancer.[12]

LUNG DISEASE – *1.5 TIMES MORE RISK*
In a demographic study of 13,792 individuals, those with periodontal disease had a 1.5 times greater risk of getting chronic obstructive pulmonary disease.[13]

OBESITY – *76% HIGHER IN YOUNG ADULTS*
In a study of 13,665 young adults (18-34) who had periodontal disease, 76% were more likely to be obese.[14]

OSTEOPOROSIS – *TREATMENT LINK*
Research has shown that treating osteoporosis can lower the severity of periodontal disease.[15]

PANCREATIC CANCER – *63% MORE RISK*
In a study of 51,529 males, it was found that men with periodontal disease had a 63% to 126% higher risk of pancreatic cancer.[16]

PREMATURE CHILDBIRTH – *79% HIGHER*
Premature low birth-weight childbirth greatly increases complications. Women with untreated periodontal disease have a 79% higher chance of premature childbirth. Treatment gives an 84% reduction in premature births.[17]

STROKE – *BACTERIA IN BLOOD CLOTS*
Periodontal bacteria have been found in blood clots and those with periodontal disease have a higher risk of stroke.[18]

TONGUE CANCER – *5 TIMES MORE RISK*
Men with advanced periodontal disease have more than five times the risk of tongue cancer.[19]

Compliments of:
John F. Darby, DDS
Timothy M. Johnson, DMD
Periodontics & Dental Implants
www.darbyandjohnson.com

Darby & Johnson, P.A.

Periodontics & Dental Implants

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WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, please check off the statements that apply to you.

Name: _____

	(Yes)	(No)
1. I am nervous being in a dental chair.	____	____
2. I have had a bad experience in a dental office.	____	____
3. I sometimes get dizzy lying back in a dental chair.	____	____
4. I have had difficulty with gagging or suctioning.	____	____
5. I would like to take breaks during long appointments.	____	____
6. My teeth or gums are very sensitive.	____	____
7. I don't like dental noises such as drilling or suctioning.	____	____
8. I haven't been to the dentist in a long time and am afraid of what you might say about my teeth or dental hygiene.	____	____
9. I would like extra care to relieve pain.	____	____
10. I am not comfortable being lectured to by doctors.	____	____
11. I will need to relay what you tell me to my spouse or another.	____	____
12. I don't like shots (or have had a bad experience with them).	____	____
13. I have concerns about the appearance of my teeth or smile.	____	____
14. I have concerns about eating, chewing, or bad breath.	____	____
15. I have concerns about insurance or finances.	____	____
16. I have another question or concern. (Please write it below)	____	____

_____

_____

Thank you for giving us your thoughts. Drs. John Darby and Timothy Johnson

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