LANDERHAVEN DENTAL ASSOCIATES

WILLIAM F. LAVIGNA, D.D.S.
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DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ______________ Zip ______________

Sex ☐ M ☐ F Age ______________

Birthdate ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) ______________ Work (_____) ______________ Ext ______ Cell Phone (_____) ______________

Spouse's Work (_____) ______________ Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone (_____) ______________________ Work Phone (_____) ______________________

WELCOME TO OUR PRACTICE!

For your health's sake, you must be accurate!

MEDICAL HISTORY

Name ______________________ Date of Birth ____________

Address ____________ City__________ Zip ________ Phone (h)__________ (w)__________

Occupation ____________ Employer ________________ S.S. No. ____________

Closest Relative ____________ Address ________________ Phone ____________

1. How would you describe your general health? ______________________

2. Are you now or have you been under the care of a medical doctor during the past two years? Yes _____ No _____

3. If yes, what condition was or is currently being treated? ______________________

4. Name(s) of physician(s) ________________ Date of Last Exam ____________

5. Have you ever been hospitalized or has a serious illness . . . . Yes _____ No _____

   if yes, please explain ______________________

6. Are you allergic to (e.g. itching, rash, swelling of hands, feet or eyes), or made sick by penicillin, aspirin, codeine, novocaine, or any other antibiotics, anesthetics or drugs . . . . Yes _____ No _____

7. Circle any of the following which you have had or have at present. Please be complete.

Rheumatic Fever	Yes	No	Bleeding Disorder (e.g., prolonged bleeding, bruise easily)	Yes	No	Thyroid Disease	Yes	No
Scarlet Fever	Yes	No				Chemotherapy (Cancer, Leukemia)	Yes	No
Heart Murmur	Yes	No						
Mitral Valve Prolapse	Yes	No				Cortisone Therapy	Yes	No
Artificial Heart Valve	Yes	No	Kidney Disorders	Yes	No	Arthritis or Rheumatism	Yes	No
Artificial Joint	Yes	No	Ulcers	Yes	No	Glaucoma	Yes	No
Heart Disease or Attack	Yes	No	Tuberculosis (TB)	Yes	No	AIDS, or HIV positive	Yes	No
Angina Pectoris (Chest Pain)	Yes	No	Asthma	Yes	No	Hepatitis or Jaundice	Yes	No
			Hay Fever	Yes	No	Drug or Alcohol Abuse	Yes	No
High Blood Pressure	Yes	No	Sinus Problems	Yes	No	Venereal Disease (Syphilis, Gonorrhea, Herpes)	Yes	No
Heart Pacemaker	Yes	No	Allergies or Hives	Yes	No			
Heart Surgery	Yes	No	Emphysema	Yes	No			
Anemia	Yes	No	Bronchitis	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Diabetes	Yes	No	Fainting or dizzy spells	Yes	No

8. Do you think you are in a high risk category to contract HIV, Hepatitis, or other bloodborne diseases? . . . . . Yes _____ No _____

9. Have you had any blood transfusions? ________________ If yes; year? __________

10. When you walk up the stairs, or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . Yes _____ No _____

11. Do your ankles swell during the day? . . . . Yes _____ No_____

12. Do you use more than 2 pillows to sleep . . . . Yes _____ No_____

13. Are you on a special diet? . . . . Yes _____ No_____

14. Do you have any disease, condition or problem not listed? . . . . Yes _____ No_____

    If yes, please explain ______________________

15. Women: Are you pregnant now? . . . . Yes _____ No_____

    Are you presently taking birth control pills? . . . . Yes _____ No_____

CURRENT MEDICATIONS

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

To the best of my knowledge, all the proceeding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at my next appointment.

______________________ Signature of patient, parent or guardian

______________________ Signature of dentist or hygienist

Date ____________ Date ____________

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Patient Acknowledgement and Consent Form

Effective April 14th 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentists or health care professional, provide information to your health care insurance, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

______________________	______________________
Patient Signature	**Patient Name (please print)**

____
Date

For Office Use Only
Patient Refused to Sign
The following circumstances prohibited the patient from signing the Acknowledgement:
☐ An emergency situation prevented the patient from signing the Acknowledgment.
☐ Other

______________________	______________________
Office Personnel (signature)	**Office Personnel (print name)**

____
Date

Patient Consent

Please sign this form under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may include types not listed above.

______________________	______________________
Patient Signature	**Patient Name (please print)**

____
Date