Geriatric Dental Group OF SOUTH TEXAS, P.A.

Fifty Plus Dental

REGISTRATION FORM

PATIENT INFORMATION

Patients name: ________________________ Social Security Number: ____________________

Relationship to patient: *(check one)*

❑ Self ❑ Responsible Party ❑ Spouse ❑ Caregiver ❑ Other____________________

Birth date: / /	Age:	Sex: ◌ M ◌ F	Do you use a wheelchair? ◌ Y ◌ N	Do you use a wheelchair? ◌ Y ◌ N

Home phone:	Cell phone:	Email:

Address:

Whom may we thank for referring you to our practice? (please check one box):

❑ Google ❑ Our website ❑ TV ❑ Newspaper ❑ Facility ____________________

❑ Other_ ____________________ ❑ Patient, Dentist or Physician ____________________

MEDICAL & DENTAL HISTORY FORM

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that addresses your overall health and well-being.

Your Primary Care Physician's name, address & phone number:

What is the date (or approximate date) of your last medical exam?

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

PROVIDER'S NAME	CONDITION THEY ARE TREATING YOU FOR
____________________	____________________
____________________	____________________
____________________	____________________

ALLERGIES

Do you have any drug allergies

Penicillin	Codeine	Sulfa	Latex
◌ Yes ◌ No	◌ Yes ◌ No	◌ Yes ◌ No	◌ Yes ◌ No

Do you have an allergy not listed above? ◌ Yes ◌ No

MEDICAL HISTORY

Please list ALL medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage and reason if possible. Attach a list if preferred.

MEDICATION / DOSAGE / REASON	MEDICATION / DOSAGE / REASON
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please indicate if you have experienced any of the following:

❑ Alcohol Use	❍ Chest pain	❍ Heart valve problems	❍ Paralysis
❑ Alzheimer's	❍ COPD / Emphysema	❍ Hepatitis B or C	❍ Parkinson's
❑ Anemia	❍ Dementia	❍ High blood pressure	❍ Radiation or Chemo
❑ Anxiety	❍ Depression	❍ Insomnia	❑ Recurrent pneumonia
❑ Aortic stenosis	❍ Diabetes	❍ Irregular heartbeats	❑ Rheumatoid Arthritis
❑ Asthma	❍ Dialysis	❍ Kidney disease	❑ Schizophrenia
❑ Atrial fibrillation	❍ Edema	❍ Liver disease	❑ Slow healing
❑ Bipolar	❍ Epilepsy or seizures	❍ Lost consciousness	❑ Thyroid – overactive
❑ Bleeding problems	❍ Fibromyalgia	❍ Low blood pressure	❑ Thyroid – underactive
❑ Blindness	❍ GERD / Heartburn	❍ Migraines	❑ Tobacco Use
❑ Blood clots	❍ Hard to swallow	❍ Neuropathy	❑ Tuberculosis
❑ Blood thinners	❍ Head & Neck Pain	❍ Osteo-Arthritis	❑ Ulcers
❑ Bronchitis	❍ Hearing loss	❍ Osteoporosis	❑
❑ Cancer	❍ Heart failure	❍ Pacemaker	❑

Do you have any other health concerns not listed here?

SURGERIES OR HOSPITALIZATIONS

❑ Heart bypass: Year ___________	❑ Heart stent placement: Year __________	❑ Heart valve replacement: Year ___________
❑ Pacemaker: Year ___________	❑ Defibrillator: Year ___________	❑ Hip replacement: Year ___________
❑ Knee replacement: Year ___________	❑ Heart attack: Year ___________	❑ Stroke: Year ___________
❑ "Mini-stroke": Year ___________	❑ Other surgeries: *(List surgery and year)* ____	

Are there any other hospitalizations we should be aware of?

Do you have any upcoming surgeries?

() No () Yes If yes, what and when: ____

DENTAL

When was your last visit to the dentist and what was done at that appointment?

Prior Dentist's name, address and phone number:

Have you ever had complications following dental treatment?

() No () Yes If yes, what happened? ____

Have you ever been told you have periodontal disease?

() No () Yes

Please mark any of the following to indicate YES in response to the question

- ❑ Do your gums bleed when you brush or floss?
- ❑ Do your teeth experience sensitivity to cold or hot temperatures?
- ❑ Are any of your teeth currently causing you pain?
- ❑ Do you grind your teeth (either consciously or during sleep)?
- ❑ Do you currently have any dental implants, dentures or partials?
- ❑ Do you experience headaches, neck aches or shoulder aches?

AGELESS SMILE EVALUATION

When you look at your smile, are there things you would like to change?

() Spaces	() Old crowns	() Denture fit
() Color	() Crooked bite	() Bad breath
() Lax facial muscles	() Chipped teeth	() Lip support
() Alignment	() Protruding teeth	() Shape of teeth
() Small teeth	() Metal margins around crowns	() Dry mouth
() Loose teeth	() Old fillings	() Other: ____________________

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I understand that if I carry dental insurance, your office will submit my insurance claim as a courtesy to me. I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment at the time of service unless prior arrangements have been made. I understand that this office provides care based on my individual needs not on the desires of my insurance company. I understand that any fee estimate listed for this dental care is valid for six months from the date on the consent form.

To avoid a cancellation fee, kindly give at least 24 hours' notice if unable to attended. Call our office at 210-617-4446.

Signature of patient, parent or guardian: ____ Date: _______________

HIPPA

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing tis consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law.
3. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ○ No ○ Yes

May we leave a message on your answering machine at home or on your cell phone? ○ No ○ Yes

May we discuss your medical condition with any member of your family? ○ No ○ Yes

If YES, please list the name of members ALLOWED: ____

Signature of patient, parent or guardian: ____________________________________ Date: _______________