Aarisha Dental

PATIENT REGISTRATION FORM

(Please Print)

yoursmile is oursmile

1. PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Ms. ❑ Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Social Security Number	Birth Date	Sex	Home Phone No.	Cell Phone No.
- -	/ /	❑ M ❑ F	( )	( )

Street Address	City	State	ZIP Code

Email Address:	Can we contact you by email? ❑ Yes ❑ No

Are you Student? ❑ Yes ❑ No ❑ Fulltime ❑ Part time	Name of School:	School City:

Employer	Occupation	Work Phone No.
		( )

Chose Office Because/ **REFERRED** to Office by (Please check one box) ❑ Dr. _____ ❑ Ins. Co. ❑ Internet

❑ Family/Friend ❑ Close to Home/Work ❑ Fliers ❑ Other

Other Family Members Seen Here (Provide Names)

2. INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
	/ /		
Is this person a patient here?	❑ Yes ❑ No		( )

Employer	Occupation	Employer Address	Work Phone No.
			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Do you have PPO/HMO Insurance ❑ PPO ❑ HMO

Name of ***Primary Insurance*** ❑ Aetna ❑ Ameritas ❑ Blue Cross / Blue Shield of _____ ❑ Cigna ❑ Delta Dental of _____

❑ Dentical ❑ DBP ❑ Dentemex ❑ Great West Life ❑ Guardian ❑ Humana ❑ Metlife ❑ Mutual Of Omaha

❑ Principal ❑ Premier Access ❑ Prudential ❑ Trustmark ❑ United Healthcare ❑ United Concordia ❑ Other (Specify)

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Insurance ID #	Ins Phone
		/ /			( )

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other (Specify)

Name of ***Secondary Insurance*** (if applicable)

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Insurance ID #	Ins Phone
		/ /			( )

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other (Specify)

3. EMERGENCY CONTACT

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

4. CONSENT FOR TREATMENT AND FIANANCIAL TERMS

CONSENT FOR TREATMENT: I hereby grant authority to the Dentist(s) at Aarisha Dental to administer any treatment or administer such anesthetics and sedatives and to perform such operations as may be deemed in the diagnosis and treatment of this patient.

TERMS AND CONDITIONS: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Dentist. I understand that I am financially responsible for any balance. I also agree to pay amount due promptly upon receipt of statement. I also authorize Aarisha Dental or Insurance Company to release any information required to process my claims.

X _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

TIME 11:54 AM AARISHA DENTAL DATE 6/6/2014

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Aarisha Dental, 43625 Mission Blvd, Suite 105, Fremont, CA 94539

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____ _____

{Please Print Name}

_____ _____

{Signature} (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

Aarisha Dental, 43625 Mission Blvd, Suite 105, Fremont, CA 94539

ACKNOWLEDGEMENT OF RECEIPT OF Dental Material Fact Sheet

****You May Refuse to Sign This Acknowledgement****

I, _____, have received from this office a copy of the Dental Material Fact Sheet.

_____ _____

{Please Print Name}

_____ _____

{Signature} (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

© 2002 American Dental Association
All Rights Reserved