TIME 03:21 PM DATE 7/21/2022

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

New Med Hist (11-1-18)(Copy)(Copy)(Copy)(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

ARE YOU UNDER A PHYSICIAN'S CARE ?	◯ Yes ◯ No	If yes
HAVE YOU BEEN HOSPITALIZED ?	◯ Yes ◯ No	If yes
HAVE YOU EVER HAD A HEAD OR NECK INJURY?	◯ Yes ◯ No	If yes
ARE YOU TAKING ANY MEDICATIONS?	◯ Yes ◯ No	If yes
DO YOU TAKE OR HAVE YOU TAKEN PHEN-FEN OR REDUX?	◯ Yes ◯ No	If yes
TAKEN- FOSAMAX,ACTONEL,BONIVA,AREDIA,ZOMETA, PROLIA,XGEVA OR OTHERS	◯ Yes ◯ No	If yes
DO YOU USE TOBACCO?	◯ Yes ◯ No	
ARE YOU ON ANY BLOOD THINNERS?	◯ Yes ◯ No	

DO YOU USE CONTROLLED SUBSTANCES?	◯ Yes ◯ No	If yes

WOMEN: ARE YOU?

☐ PREGNANT/TRYING TO GET PREGNANT? ☐ TAKING ORAL CONTRACEPTIVES? ☐ NURSING?

☐ TAKING HORMONE THERAPY ☐ HAVE YOU REACHED MENOPAUSE?

ARE YOU ALLERGIC TO THE FOLLOWING?

☐ ASPRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC

☐ METAL ☐ LATEX ☐ SULFA DRUGS ☐ LOCAL ANETHETICS

☐ CLINDAMYCIN

OTHER? ☐ If yes

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

MITRO VALVE PROLAPSE ◯ Yes ◯ No	ANGINA PECTORIS ◯ Yes ◯ No	LIVER DISEASE ◯ Yes ◯ No	ARTIFICIAL HEART VALVE ◯ Yes ◯ No
HIGH BLOOD PRESSURE ◯ Yes ◯ No	ULCERS ◯ Yes ◯ No	RHEUMATIC OR SCARLET FEVER ◯ Yes ◯ No	FEVER BLISTERS ◯ Yes ◯ No
HEART MURMUR ◯ Yes ◯ No	THYROID DISEASE ◯ Yes ◯ No	HEART FAILURE OR DISEASE ◯ Yes ◯ No	KIDNEY TROUBLE ◯ Yes ◯ No
BLOOD TRANSFUSION ◯ Yes ◯ No	CANCER ◯ Yes ◯ No	DRUG ADDICTION ◯ Yes ◯ No	JOINT REPLACEMENT (HIP OR KNEE) ◯ Yes ◯ No
ARTHRITIS ◯ Yes ◯ No	TUBERCULOSIS ◯ Yes ◯ No	INFECTIOUS ENDOCARDTIS ◯ Yes ◯ No	HIV POSITIVE ◯ Yes ◯ No
BRUISE EASILY ◯ Yes ◯ No	VENEREAL DISEASE ◯ Yes ◯ No	EPILEPSY OR SEIZURE ◯ Yes ◯ No	STOMACH PROBLEMS ◯ Yes ◯ No
HEPATITIS B OR C ◯ Yes ◯ No	PSYCHIATRIC CARE ◯ Yes ◯ No	GLAUCOMA ◯ Yes ◯ No	PARKINSON'S DISEASE ◯ Yes ◯ No
FAINTING OR DIZZINESS ◯ Yes ◯ No	SINUS TROUBLE ◯ Yes ◯ No	SLEEP APNEA ◯ Yes ◯ No	SNORING ◯ Yes ◯ No
LOW BLOOD PRESSURE ◯ Yes ◯ No	ASTHMA ◯ Yes ◯ No	YELLOW JAUNDICE ◯ Yes ◯ No	LUNG DISEASE ◯ Yes ◯ No
CHEMOTHERAPY ◯ Yes ◯ No	OSTEOPOROSIS ◯ Yes ◯ No	PACE MAKER ◯ Yes ◯ No	PAIN IN JAW ◯ Yes ◯ No
LEUKEMIA ◯ Yes ◯ No	EMPHYSEMA ◯ Yes ◯ No	DEMENTIA ◯ Yes ◯ No	HEPATITIS A ◯ Yes ◯ No
DIABETES ◯ Yes ◯ No	EXCESSIVE THIRST ◯ Yes ◯ No	EXCESSIVE BLEEDING ◯ Yes ◯ No	CORTISONE MEDICINE ◯ Yes ◯ No
HIVES OR RASH ◯ Yes ◯ No	HYPOGLYCEMIA ◯ Yes ◯ No	IRREGULAR HEART BEAT ◯ Yes ◯ No	FREQUENT HEADACHES ◯ Yes ◯ No
GENITAL HERPES ◯ Yes ◯ No	TONSILITIS ◯ Yes ◯ No	TUMORS OR GROWTHS ◯ Yes ◯ No	SHINGLES ◯ Yes ◯ No
SICKLE CELL DISEASE ◯ Yes ◯ No	HEMOPHILIA ◯ Yes ◯ No	CHEST PAINS ◯ Yes ◯ No	COLD SORES ◯ Yes ◯ No
CONGENITAL HEART DISORDER ◯ Yes ◯ No	CONVULSIONS ◯ Yes ◯ No	ANAPHYAXIS ◯ Yes ◯ No	EASILY WINDED ◯ Yes ◯ No
BLOOD DISEASE ◯ Yes ◯ No	STROKE ◯ Yes ◯ No	RADIATION ◯ Yes ◯ No	HIGH CHOLESTROL ◯ Yes ◯ No
RENAL DIALYSIS ◯ Yes ◯ No			

COMMENTS:

ALL QUESTIONS HAVE BEEN ASNSWERED TO THE BEST OF MY KNOWLEGDE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH AND THE STAFF.IT IS MY RESPONSIBILITY TO LET THE OFFICE KNOW OF ANY MEDICAL CHANGES.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

HIPPA PATIENT CONSENT FORM

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize the office of Dr. Pereira, DMD to use and disclose my protected health information to carry out the following:

- Treatment (conduct, plan and direct my treatment and follow-up among multiple healthcare provider who may be involved in treatment directly or indirectly)
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I have been informed of and given the right to review and secure a copy of The Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that this office deserves the right to change the terms of this notice from time to time and I may contact this office at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but this office is not required to agree to these restrictions. I understand that I may revoke this consent at any time, however this office may condition/restrict treatment. I understand no insurance can be billed on my (patient's) behalf without this signed HIPPA consent form.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Signed Date: _____

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

PHOTO CONSENT FORM

I, _____ grant permission to _____ for the use of the photograph(s) or electronic media images as identified below in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying _____ in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

Signature _____ **Date** _____

Image(s) Description _____

_____