MARIA VAN HUFFEL, DDS

General Dentist

Thank you for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name_____ Today's Date_____

Soc. Sec. #_____ Birthdate_____ DL#_____

Home Address(not PO Box)_____

City_____ State_____ Zip Code_____

Would you like to receive appointment reminders by email?:_____

Mailing Address (if different than above)_____

Circle appropriate Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Home Phone_____ Work Phone_____ Cell/Pager_____

Employer_____ Occupation_____

Business Address_____

Spouse/Partner Name_____ Work Phone_____

Whom/what may we thank for referring you?_____

Person to contact in case of emergency (*someone who does not live with you)*

Responsible Party

Name of person financially responsible for this account_____

Relationship to patient_____ Is this Person a Patient in Our Office?_____

Address (if different from above)_____

City_____ State_____ Zip Code_____

Soc. Sec. #_____ Birthdate_____ DL#_____

Home Phone_____ Work Phone_____ Cell/Pager_____

Primary Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Soc. Sec. #_____ Birthdate_____ DL#_____

Name of Employer_____ Date Employed_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Emp. #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Additional Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Soc. Sec. #_____ Birthdate_____ DL#_____

Name of Employer_____ Date Employed_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Emp. #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

over please

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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 _____

Patient Dental History Name of Previous Dentist _____ Last exam date _____

Do your gums bleed?	☐yes no ☐	Do you have pain or sensitive teeth?	☐yes no ☐
Do you clench/grind your teeth?	☐yes no ☐	Do you have sores/lumps in mouth?	☐yes no ☐
Do you bite your lips/cheeks?	☐yes no ☐	Do you wear dentures/partials?	☐yes no ☐
Do you like your smile/color of teeth?	☐yes no ☐	Have you had head/neck/jaw injuries?	☐yes no ☐
Have you had orthodontic treatment?	☐yes no ☐		

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

_____
Signature Date

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Health Insurance Portability and Accountability Act

PATIENT NAME_____

Please answer all questions by circling appropriate answer/filling in blanks. Thank you.

- **May we audibly say your name in our patient lobby, in order to identify you?**
  ☐ **YES** ☐ **NO**
- **May we use all of your contact numbers and addresses to stay in touch with you?**
  ☐ **YES** ☐ **NO**
- **May we leave messages in your absence?**
  ☐ **YES** ☐ **NO**
- **With whom may we discuss your dental care?**
  Name:_____ Relationship:_____
- **Who can pick up your written prescriptions?**
  Name:_____ Relationship:_____
- **We routinely give reminder calls prior to appointments. Where can we reach you?_____**
- **May we call you at work?**
  ☐ **YES** ☐ **NO**

CONSENT RELATED TO THE PRIVACY NOTICE: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

_____

SIGNATURE OF PATIENT/GUARDIAN_____

DATE OF BIRTH_____ **DATE_____**

PATIENT UNABLE TO SIGN DUE TO _____

PATIENT REFUSED TO SIGN
WITNESS_____ **DATE_____**

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APPOINTMENT GUIDELINES & AGREEMENT

Since providing quality treatment for all of our patients in a timely manner is a major focus of our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor.

There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hours notice and that you contact us during business hours, this would allow us the opportunity to give this time to another patient who is in need and waiting.

Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Thank you.

_____ _____

Patient **Date**

Maria Van Huffel, D.D.S._____ (initial)