Patient Registration Form
Periodontology-ARID

Patient Name: _____ D.O.B_____ Today's Date_____

Address: _____City: _____State: ____Zip: _____

Phone (H/W): _____ Cell: _____

E-mail_____ I do not have e-mail O

May we send you an e-mail appointment reminder? Yes ONo O

Whom should we THANK for referring you? _____

Please give us the following information to facilitate our communication with your primary care M.D.:

Primary Care Name: _____ Phone: _____

*******Please bring insurance card to your appointment*******

Primary Insurance_____ Policy #_____ Group #_____

Cardholder Name_____ Cardholder D.O.B ___/___/____

Relationship_____

Secondary Insurance_____ Policy #_____ Group #_____

Cardholder Name_____ Cardholder D.O.B ___/___/____

Relationship_____

Please give us the following information to facilitate getting your prescriptions filled:

Pharmacy Name: _____ Phone #: _____ Address: _____

I have been able to review Notice of Privacy Practices (available in our office or on our web site). This notice provides information about how P-ARID/ARID may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at P-ARID/ARID for clarification. Yes O Not Yet O

Patient Signature_____Date_____

Periodontology-ARID

Patient Name: _____ Today's Date: _____

Please read and darken the circle for the appropriate response regarding your medical history.

**********Female Patients Only **********

Currently Pregnant **O** Yes **O** No

Currently Breastfeeding **O** Yes **O** No

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General

Allergies to Medications **O** Yes **O** No

Problems with Anesthesia **O** Yes **O** No

History of Cancer **O** Yes **O** No

Eyes

Vision Problems **O** Yes **O** No

Eye Pain/Discomfort **O** Yes **O** No

Neurological

Frequent or Severe Headache **O** Yes **O** No

Numb/Tingling Hands or Feet **O** Yes **O** No

Endocrine

Diabetes **O** Yes **O** No

Always Tired/ Sluggish **O** Yes **O** No

Cardiovascular

Pacemaker **O** Yes **O** No

Chest Pain **O** Yes **O** No

High Blood Pressure **O** Yes **O** No

Heart Valve Problem **O** Yes **O** No

Musculoskeletal

Joint Replacement **O** Yes **O** No

Joint Pain/Arthritis **O** Yes **O** No

Gastrointestinal: Recent or Frequent

Abdominal Pain	**O** Yes	**O** No
Nausea/Vomiting	**O** Yes	**O** No
Indigestion/Heartburn	**O** Yes	**O** No

Ear/Nose/Throat: Recent or Frequent

Ear Infection	**O** Yes	**O** No
Sore Throat	**O** Yes	**O** No
Sinus Problems	**O** Yes	**O** No

Respiratory/Allergic

Wheezing/ Asthma	**O** Yes	**O** No
Frequent Cough	**O** Yes	**O** No
Hay Fever	**O** Yes	**O** No

Hematologic/Lymphatic

Bleeding Problems	**O** Yes	**O** No
Blood Clot or Stroke	**O** Yes	**O** No

Psychological

Anxiety Disorder	**O** Yes	**O** No
Mood Swings	**O** Yes	**O** No
Depression	**O** Yes	**O** No

Darken the circle if the answer is YES:

O Aspirin? Dosage_____

O Herbal medication? _____

O Smoke?

O Recreational Drug?

O Drink alcohol?

O Currently work? Occupation (optional) _____

O Live alone?

Please list any prescription medications you are regularly taking:

_____ _____
_____ _____
_____ _____

Please list any nonprescription medications you are regularly taking:

_____ _____
_____ _____
_____ _____

Please list any allergies to medications:

_____ _____

Please list prior surgeries (medical/dental) with approximate date of procedure: (last 5 years)

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

Please describe any medical problems you checked ""yes" " to on the prior medical history sheet, or any other medical issues you have that were not listed:

_____ _____
_____ _____
_____ _____

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively.