Urgent Dental Care of New Hampshire
Patient Registration Form

How did you hear about us? _____
How Long Since Your Last Dental Visit_____
Are you experiencing any dental problems at this time_____

Patient First Name_____ Last Name_____
Date of Birth_____ S.S. Number_____
Email address (this will help us confirm your appointments, we will not share your email with anyone or send you spam mail)_____
Mobile Phone_____ Home Phone_____
Office Phone_____ Which Phone preferred?_____
Home address_____ City_____
State _____ Zip Code_____
Employer_____ Work Phone_____
Employer's Address_____
Emergency Contact Name_____ Relationship to patient_____
Emergency contact Phone(s)_____
What is your Marital Status? Single □ Married □ Widowed □
Spouse's Name_____ Spouse's Date of Birth_____
Spouse's Employer_____ Spouse's Work Phone_____

Dental Insurance company_____ Group #_____
Insurance company phone_____

For patients under 18 years of age
Parent or Guardian information: Mother □ Stepmother □ Guardian □
Name_____ Address_____
City_____ State_____ Zip Code_____
Mobile Phone_____ Home Phone_____ Work Phone_____
Employer_____ Occupation_____
Employer Address_____ S.S. #_____
Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

Parent or Guardian information: Father □ Stepfather □ Guardian □
Name_____ Address_____
City_____ State_____ Zip Code_____
Mobile Phone_____ Home Phone_____ Work Phone_____
Employer_____ Occupation_____
Employer Address_____ S.S. #_____
Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

I hereby authorize Urgent Dental Care of NH and its affiliates to provide me (or my child) any advisable, necessary dental procedures, medications, or anesthetics to be administered by the doctors or staff for diagnostic purposes or dental treatment. I understand that my care may be referred to dental specialists or affiliated practices when necessary. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage, which may only be estimated at time of treatment. Insurance estimates are not a guarantee of reimbursement.

Signature of Patient, Parent or Guardian_____ Date_____

Urgent Dental Care of New Hampshire

Patient Medical History

Patient Name:_____ **Date:**_____

Are you currently under the care of a physician to treat a medical condition: **Yes** **No** if yes, please explain:_____

_____

Please list all **Medications** you are taking: _____

_____

_____

Do you currently have any dental pain or dental issues you are concerned about: **Yes** **No** if yes, please explain:_____

_____

Do you use Tobacco products: **Yes** **No** if yes, explain type and frequency_____
Do you use controlled substances **Yes** **No** if yes, please list_____

WOMEN:
Are you pregnant or trying to get pregnant: ***Yes*** ***No***
Are you Nursing: ***Yes*** ***No***
Are you taking oral contraceptives ***Yes*** ***No***

Are you taking any anticoagulant medications or **Blood Thinners:** **Yes** **No** if yes, please list:_____
Are you taking any **Osteoporosis Bisphosphonate** Medications: **Yes** **No** if yes, please list:_____
Do you have a **Heart Condition** or have a **Pacemaker:** **Yes** **No** if yes, pleas explain_____
Do you have any conditions that cause **excessive bleeding**: **Yes** **No** if yes, please explain_____

Are you **Allergic** to any Medications **Yes** **No** if yes, please list and explain reaction:_____

_____

Are you **Allergic** to any of the following? Antibiotics☐ Penicillin drugs☐ Clindamycin☐ Local Anesthetics☐ Latex☐ Metal☐ Acrylic☐ Ibuprofen☐ Aspirin☐ Naproxen☐ Tylenol☐ Codeine☐ Percocet☐ Vicodin☐ Other☐ please explain reaction to any:_____

_____

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 my 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:_____

AUDC Dental Group, PLLC
DBA Amoskeag Family Dentistry
& Urgent Dental Care of NH

NOTICE OF PRIVACY ACKNOWLEDGEMENT(HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not limited to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly including any other dentists or specialist to whom we are referring you to for treatment or evaluation.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your full length Notice of Privacy Practices or understand that I may request a copy of it at any time. The full length agreement contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I am being advised that I may receive phone, email or text messages about my appointments as well as messages left on answering machine or voicemail and I must request in writing if I do not wish to receive such communications. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

May We Discuss your medical/dental conditions with any member of your family or trusted individual? (please circle one) **YES** **NO**

If Yes, please name the individual(s) allowed:

_____

Patient Consent Signed by (print name) :_____

Relationship to patient: _____

Signature:_____ Date:_____