PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (_____) _____ Alt. Phone (_____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (_____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (_____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified?_____ Phone (_____)_____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Heart Problems
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory Problems
☐ Nervous Problems
☐ Radiation Treetment
☐ Artificial Heart Valves or Joints
☐ Recent Weight Loss
☐ Back Problems
☐ Diabetes
☐ Respiratory Disease
☐ Epilepsy
☐ Headaches
☐ Hepatitis, Jaundice or Liver Disease
☐ Cancer
☐ Psychiatric Care
☐ Chronic Diarrhea
☐ Allergies to Anesthetics
☐ Allergies to Medicine or Drugs
☐ General Allergies
☐ Blood Disease
☐ Arthritis
☐ Special Diet
☐ Swollen Neck Glands
☐ Rheumatic Fever
☐ Sinus Problems
☐ HIV / AIDS or Other Immunosuppressive Disorders
☐ Thyroid Disease
☐ Stroke
☐ Ulcer
☐ Venereal Disease
☐ Chemical Dependency
☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please descrube_____

_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Bonvia ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively reffered to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____
Name of Insurance Company(ies)

and assign directly to Dr._____all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all Information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
and authorize the dental staff to preform necessary dental services for my child, including by not limited to X-rays, and administration of anesthetics which are deemed advisable by the dorcor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I achnowledge that payment is due at the time of treatment, unless orther arrangements are made.I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since yourlast dental appointment? ☐Yes ☐No

For what conditions?_____

Are you taking any new medications?_____ If so , what_____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since yourlast dental appointment? ☐Yes ☐No

For what conditions?_____

Are you taking any new medications?_____ If so , what_____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

PHILLIP A TYNDALL, DDS, PC
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgment.

I have been offered and / or received a copy of Dr. Tyndall's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and / or third party. I understand that I may request a copy of the privacy policies at any time.

Expiration -- 3 years from initial Signature; Insurance Change; Pt reaches age of 18 _____

I consent for the office of Dr. Phillip Tyndall to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ /_____/ _____

_____ /_____/ _____

_____ /_____/ _____

Signature: _____

Tyndall
FAMILY DENTISTRY