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

Who referred you?

Last dental cleaning

Previous dentist

Last exam and xrays

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:

Michael R. Windauer, D.M.D.

Medical History 7-2015(Copy)

Patient Name: Birth Date: Date Created:

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	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No		
Do you use tobacco?	○ Yes ○ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex
☐ Sulfa Drugs ☐ Local Anesthetics ☐ Erythromycin ☐ Amoxicillin

Do you use controlled substances?	○ Yes ○ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Angina/chest pains	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No	Autism	○ Yes ○ No	ADHD	○ Yes ○ No
Bleeding Problems	○ Yes ○ No	Cancer/Chemo Treatments	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	COPD	○ Yes ○ No
Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
GE Reflux	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Heart Surgery	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Liver Disease	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Renal Dialysis	○ Yes ○ No	Stroke	○ Yes ○ No	Tuberculosis	○ Yes ○ No		

Have you ever had any condition not listed above? ○ Yes ○ No If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

I hereby authorize Dr. Michael Windauer to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Windauer to make a thorough diagnosis of my dental needs. I also authorize Dr. Windauer to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I understand that this office policy is to collect payment at the time of service; and any insurance estimation of payment is done as a courtesy for me and not a written guarantee of what I will owe for treatment. I also assign benefits to be paid by my insurance company directly to Dr. Windauer for services rendered. I understand that despite insurance benefits I am responsible for services rendered and agree to pay my balance with 30 days of treatment whether or not my insurance company has responded to my claim for treatment.

I further authorize the release/request of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to my insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

I have been made aware that a copy of the office's Notice of Privacy Practices is available to me at my request.

Parent/Guardian:_____ Date_____

(Please print)

Signature:_____Date_____

NEW PATIENT QUESTIONNAIRE

FRONT TEETH

Are you happy with their color?	YES	NO
Are you happy with their length?	YES	NO
Are they crooked?	YES	NO
Are you happy with their overall appearance?	YES	NO

BACK TEETH

Are they sensitive to hot or cold?	YES	NO
Do they trap food when you eat?	YES	NO

GUMS

Do they ever bleed?	YES	NO
Are your gums sensitive?	YES	NO
Do you feel like you have bad breath?	YES	NO

MISSING TEETH

Do you have any missing teeth?	YES	NO
Are you wearing a partial or full denture?	YES	NO

Does dental treatment make you nervous? YES NO

Have you ever had a bad experience at the dentist?

If yes, please explain:

Have you had any complications following treatment?

If yes, please explain: