PATIENT REGISTRATION FORM – DENTAL CLINICS

(Please Print Clearly) «Patient_Full_Name» «Patient_Primary_Code»

PATIENT INFORMATION

Last name: «Patient_Last_Name»	First: «Patient_First_Name»	Middle: «Patien	Sex: ❑ F ❑ M ❑ T
Birth date: «Patient_Birthdate»	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Communication preference for appointment reminders (may select both): ❑ Text ❑ E-mail (provide e-mail address below)	E-Mail:
Street address: «Patient_Address1»	Apt/Unit: «Patient_Address2»	Home phone: ( )	❑ Primary
City: «Patient_City»	State: «Patie	ZIP Code: «Patien	Work phone: ( ) ❑ Primary
Employer:	City & State	Mobile phone: ( )	❑ Primary
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline	Race: ❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Mixed Race ❑ Decline	Interpreter Needed? ❑ Yes ❑ No If Yes, Language needed:	
Emergency Contact	Last Name:	First Name:	Phone: ( )
Relation to Patient: ❑ Spouse/Partner ❑ Child ❑ Parent ❑ Sibling ❑ Grandparent ❑ Legal Guardian ❑ Other			

PERSON RESPONSIBLE FOR THE BILL (ONLY IF DIFFERENT FROM PATIENT)

❑ This person is a patient here	Last Name:	First:	Middle:	Sex: ❑ F ❑ M ❑ T
Street address:	Apt/Unit:	Home phone: ( )		
City:	State:	ZIP Code:	Alternate phone: ( )	
Birth date: / /	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	Employer Name: City:	State:	

INSURANCE INFORMATION (A copy of your insurance card is required)

Is this patient covered by a Minnesota Health Care Program? ❑ Yes ❑ No	ID#	Group #	
Policy Holder: Last name: ❑ Patient is Policy Holder	First:	Middle:	Sex: ❑ F ❑ M ❑ T
Street address: ❑ Same as Patient	Apt/Unit:	Home phone: ( )	
City:	State:	ZIP Code:	Alternate phone: ( )
Birth date: / /	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	Employer Name: City:	State:
Insurance Name:	❑ Dental ❑ Medical	Group Number:	Policy Holder/ Subscriber ID: /
Insurance Billing Address:	City	State	Insurance Start Date: M Y

SECONDARY INSURANCE INFORMATION

Policy Holder: Last name: ❑ Patient is Policy Holder	First:	Middle:	Sex: ❑ F ❑ M ❑ T
Street address: ❑ Same as Patient	Apt/Unit:	Home phone: ( )	
City:	State:	ZIP Code:	Alternate phone: ( )
Birth date: / /	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	Employer Name: City:	State:
Insurance Name:	❑ Dental ❑ Medical	Group Number:	Policy Holder/ Subscriber ID: /
Insurance Billing Address:	City	State	Insurance Start Date: M Y

Patient Name: «Patient_Full_Name»

University of Minnesota
School of Dentistry Clinics

Consent for treatment: I hereby authorize the faculty of the School of Dentistry (School) and the students and staff working under their supervision, to perform ordinary diagnostic procedures, including x-rays and photographs, to determine the general nature of my dental problems. I understand that the benefits, alternatives, discomforts and risk relating to my dental treatment will be explained to me in terms that I understand and properly annotated in my chart using appropriate consent forms before treatment is initiated. My special consent will be obtained for procedures such as general anesthesia, sedation or procedures with potential complications as determined by the attending dental specialist.

Consent for photos: I consent to be interviewed/photographed/audiotaped/videotaped for the purpose of education and medical instruction as the University of Minnesota's School of Dentistry deems appropriate. I further consent that such Information/photography/audiotape/videotape shall be the exclusive property of the Regents of the University of Minnesota, free and clear of any claim on my part.

Consent for Assignment of Insurance benefits: I authorize the payment of insurance benefits otherwise payable to me directly to the School. The School may share my medical and financial information with Medicare, other government payers, and accident or health insurers for the purpose of payment, claims processing, fraud investigations or quality of care reviews. When benefits are not paid to the School amounts owing are due immediately.

Collection costs: I agree to reimburse the School for the costs and expenses incurred by the School in connection with the collection of amount(s) due hereunder, including reasonable attorneys' fees and related costs.

Payment: I understand as a patient or as the responsible party that I agree to pay for services provided. Down payments are required for services incurring laboratory expenses. Payment options in the graduate orthodontic program will be discussed when you meet with the Orthodontic Clinic financial coordinator.

Patient Brochure and Patient Bill of Rights: I agree that I have received a copy of the brochure entitled, "Patient Information Brochure and Patient Bill of Rights" that contains information about the following:

- My rights and responsibilities as a patient
- Payment for services
- Fee estimates
- Treatment policies and appointments
- Cancelling appointments and fail policy
- How to contact us 612-625-6444

University of Minnesota Acknowledgement of Notice of Privacy Practices Form: I have received the University of Minnesota HIPAA Notice of Privacy Practices.

I HAVE CROSSED OUT AND INITIALED STATEMENTS TO WHICH I DO NOT CONSENT OR AGREE.

(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) LEGAL RELATIONSHIP DATE

University of Minnesota Dental Clinics

Medical and Dental Questionnaire

Dental Record Number «Patient_Primary_Code

Patient Name «Patient_Full_Name»

Date of Birth «Patient_Birthdate»

Mark your response to indicate if you have had any of the following diseases or problems.
Mark **don't know (Dk)** if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or problem in the space at the bottom of this form.

Yes	No	Dk		
☐	☐	☐	Do you have tuberculosis?	
☐	☐	☐	Are you Pregnant or nursing?	
Date of last physical examination: _____				
☐	☐	☐	Any changes in your health within the past year?	
Physician Name: _____				
Phone: _____				
			Cardiovascular	
☐	☐	☐	High blood pressure	
☐	☐	☐	Angina (chest pain)	
☐	☐	☐	Heart attack	
☐	☐	☐	Irregular heart beat	
☐	☐	☐	Heart surgery	
☐	☐	☐	Heart failure	
☐	☐	☐	Damaged heart valve	
☐	☐	☐	High cholesterol	
☐	☐	☐	Heart infection	
☐	☐	☐	Stroke	
			Hematologic	
☐	☐	☐	Anemia	
☐	☐	☐	Sickle cell anemia	
☐	☐	☐	Abnormal bleeding	
			Respiratory	
☐	☐	☐	Asthma	
☐	☐	☐	Emphysema/bronchitis	
☐	☐	☐	Sleep apnea	
☐	☐	☐	Difficulty breathing	
☐	☐	☐	Tuberculosis	
			Endocrine	
☐	☐	☐	Diabetes	
☐	☐	☐	Thyroid problem	
			Renal	
☐	☐	☐	Kidney disorder	
☐	☐	☐	Dialysis	
			Immune	
☐	☐	☐	Past use of steroids	
☐	☐	☐	Delayed healing	
			Musculoskeletal	
☐	☐	☐	Arthritis	
☐	☐	☐	Artificial joint	
☐	☐	☐	Fibromyalgia	
☐	☐	☐	Lupus	
☐	☐	☐	Sjogren's Syndrome	
☐	☐	☐	Osteoporosis	
			Gastrointestinal	
☐	☐	☐	Acid reflux/GERD	
☐	☐	☐	Irritable bowel syndrome	
☐	☐	☐	Stomach ulcer	
			Hepatic	
☐	☐	☐	Liver disease	
☐	☐	☐	Jaundice	
☐	☐	☐	Hepatitis	
			Neurologic	
☐	☐	☐	Epilepsy/seizures	
☐	☐	☐	Parkinson's Disease	
☐	☐	☐	Multiple sclerosis	
☐	☐	☐	Headaches	
			Skin	
☐	☐	☐	Hives or skin rash	
☐	☐	☐	Other skin lesions	
			Eyes/Ears	
☐	☐	☐	Glaucoma	
☐	☐	☐	Impaired vision	
☐	☐	☐	Impaired hearing	
			Mental Health	
☐	☐	☐	Bipolar disorder	
☐	☐	☐	Depression	
☐	☐	☐	Anxiety	
☐	☐	☐	Eating disorders:	
☐	☐	☐	Anorexia	
☐	☐	☐	Bulimia	
☐	☐	☐	Sleep disorders	
☐	☐	☐	Dementia	
☐	☐	☐	Learning disorders	
			Infections	
☐	☐	☐	HIV positive/AIDS	
☐	☐	☐	Sexually transmitted disease	
			Allergies	
☐	☐	☐	Local anesthetic	
☐	☐	☐	Antibiotics	
☐	☐	☐	Aspirin/ibuprofen	
☐	☐	☐	Acetaminophen (Tylenol)	
☐	☐	☐	Codeine/narcotics	
☐	☐	☐	Metals	
☐	☐	☐	Latex	
☐	☐	☐	Other:_____	

(Please continue on opposite side)

Yes No **Cancer**

- ☐ ☐ Head and neck cancer
- ☐ ☐ Head and neck radiation therapy
- ☐ ☐ Family history of oral cancer
- ☐ ☐ Other cancer
- ☐ ☐ Type _____
- ☐ ☐ Location_____
- ☐ ☐ Previous cancer treatment
- ☐ ☐ Are you presently undergoing chemotherapy

Yes No **Tobacco Use**

- ☐ ☐ Average # of Packs/day _____
- ☐ ☐ Number of years

Yes No **Alcohol Use**

- ☐ ☐ Average # of drinks/week _____

Yes No **Chemical Dependency**

- ☐ ☐ Marijuana
- ☐ ☐ Methamphetamines

Yes No Dk **Additional Health Information**

☐ ☐ ☐ Patient has had additional health issues And/or surgeries_____

_____

_____

_____

_____

_____

_____

Yes No Dk **Current Vaccinations**

☐ ☐ ☐

Yes No Dk Influenza

☐ ☐ ☐

Yes No Dk Pneumoccocal

☐ ☐ ☐

Yes No Dk Human papillomavirus – HPV

☐ ☐ ☐

Yes No Dk Varicella

☐ ☐ ☐

Dental Questions

Yes No Dk Has injured head, neck, or jaw

☐ ☐ ☐

Yes No Dk Has difficulty eating or swallowing

☐ ☐ ☐

Yes No Has had had a change in the ability to taste foods

☐ ☐

Yes No Has a dry mouth

☐ ☐

Does patient Routinely:

Yes No Snack prior to bedtime

☐ ☐

Yes No Use sweetened liquids such as coffee, tea, Pop, fruit, or sports drinks

☐ ☐

Yes No Use sugared gum

☐ ☐

Yes No Use hard candy or breath mints

☐ ☐

Yes No Use sugar-containing medications (antacids, cough drops/syrup, sweetened suspensions)

☐ ☐

Yes No Presently participating in a smoking cessation program

☐ ☐

Yes No Has had a major lifestyle change within the past year

☐ ☐

Yes No **Has special needs**

- ☐ ☐ Blind/Visually Impaired
- ☐ ☐ Deaf/hearing impaired
- ☐ ☐ Requires wheelchair
- ☐ ☐ Requires caregiver
- ☐ ☐ Requires interpreter
- ☐ ☐ Has Legal guardian
- ☐ ☐ Other

To the best of my knowledge, the preceding information is complete and correct.

_____ _____

Signature – Patient (or parent/guardian if patient is under 18) **Date**

****

University of Minnesota School of Dentistry

«Patient_Full_Name»
«Patient_Primary_Code»
«Patient_Birthdate»

Medication List

Physician: Name _____ Phone#_____

Address_____

Are you under the care of a Specialist: (i.e. Cardiologist, Orthopedic Surgeon, etc.)

Name_____ Type_____ Phone # _____

Address_____

Reason for today's dental visit_____

Date of last dental visit _____ Do you have x-rays? _____

You may have X-rays from another provider emailed to the Clinic at umortho@umn.edu. Additional x-rays may need to be taken in order to provide a proper diagnosis and to develop an appropriate treatment plan. Non-electronic copies or prints of x-rays are usually not of good diagnostic value.

Dental Office Name _____

Address_____

Phone# _____ Fax # _____

I have received bisphosphonate therapy (i.e. Fosamax, Boniva, Actonel, etc.) Yes__ No__
I have received corticosteroid therapy (Prednisone, Betamethasone, etc.) Yes__ No__
I have received IV cancer medication. Yes__ No__

Pharmacy Name_____ Phone # _____ Fax #_____

Pharmacy Address _____

Patient to fill out prior to visit

Medication Including Homeopathic, Herbal, Dietary supplements, and Recreational Drugs	Dose/Frequency	Condition prescribed for:	Date Started MM/YYYY
(Example) Simvastatin	**20 mg 2 x day**	**High Cholesterol**	**06/2014**