

Eric E. Schuh, D.D.S
Marissa Stroube, D.D.S.

Date _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

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

Section 3

Employment Status: Full Time Part Time Retired

Cell Phone #: _____

Student Status: Full Time Part Time

Pager #: _____

Medicaid ID: _____ Pref. Dentist: _____

Emergency Contact #: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

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: _____ .00 Rem. Deduct: _____ .00

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: _____ .00 Rem. Deduct: _____ .00

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

	Yes	No	
Are you under a physician's care now?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/>	<input type="radio"/>	_____
Are you on a special diet?	<input type="radio"/>	<input type="radio"/>	_____
Do you use tobacco?	<input type="radio"/>	<input type="radio"/>	
Do you use controlled substances?	<input type="radio"/>	<input type="radio"/>	

Women: Are you:

Pregnant / Trying to get pregnant? Yes No Yes No Nursing? Yes No

Are you allergic to any of the following (check if yes)?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? **Please check if Yes**

- | | | | |
|---|---|---|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Rheumatism |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood Pressure | <input type="radio"/> Shingles |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hives or Rash | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypoglycemia | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Kidney Problems | <input type="radio"/> Stomach/intestinal Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Leukemia | <input type="radio"/> Stroke |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Liver Disease | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Lung Disease | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Ulcers |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Heart Murmur | <input type="radio"/> Psychiatric Care | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Radiation Treatments | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Recent Weight Loss | |

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

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 _____ DATE _____

Eric E. Schuh, D.D.S., PC
Marissa Stroube, D.D.S.
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Gallatin, Tennessee 37066
Phone:(615) 230-6611
Fax: (615) 230-6614

In an effort to acknowledge our referral sources we would like to know who referred you to our office or how you heard about us. Please check all that apply:

- Newspaper Ad
- Yellow Pages Ad
- Current Patient (name of patient: _____)
- Another Doctor's Office (name of Doctor: _____)
- Dr. Schuh's Website
- Insurance PPO List
- Other (please specify: _____)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ERIC E. SCHUH, DDS MARISSA STROUBE, DDS

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 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.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing 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 at the address above 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 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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