Garrison Family Dentistry
129-D University Blvd.
Harrisonburg, VA 22801
540-434-5702
smiles@garrisongfd.com

Dental History and Registration Form
(Please Print)
Date:_____

Patient Information

Name_____
Last Name First Name Initial Preferred Name
SSN _____

Address_____

City_____ State_____ Zip_____

Home # _____ Cell # _____

Male or Female Age_____ Date of Birth _____ Marriage Status _____

Patient Employed by_____ Occupation _____

Business Address _____ Business # _____

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

Whom may we thank for referring you to our office? _____

Primary Insurance

(If we already have this information scanned in or if you are self pay, no need to fill out)

Policy holder _____
Last Name First Name Initial

Employer _____ Occupation _____

Insurance carrier name _____ Contact phone # _____

Member ID number _____Group number _____

Relationship to the patient _____ Date of Birth_____ SSN_____

Address (if different from patient's)_____ Phone _____

City_____ State _____ Zip_____

Names of other dependents covered under this plan _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, Insurance Company

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 insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

GARRISON FAMILY DENTISTRY

Welcome!

Thank you for taking the time to complete this health history form. Your overall health affects your oral health and your dental care. Our team is committed to thoughtful, personalized care and we look forward to supporting you.

Confidential Dental and Health History

Dental Information *Please mark (x) your responses to the following questions*

What is the reason for your dental visit today? Are you currently experiencing dental pain or discomfort?					
When was your last dental visit? What was done at that time?					
	Yes	No		Yes	No
Do your gums bleed when you brush or floss?.....	☐	☐	Do you get food stuck between your teeth?.....	☐	☐
Are your teeth sensitive?	☐	☐	Do you have clicking, popping or discomfort in your jaw?	☐	☐
Is your mouth dry?.....	☐	☐	Do you clinch or grind your teeth?.....	☐	☐
Do you feel that you have bad breath?.....	☐	☐	Do you have cold sores or ulcers?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Do you have missing teeth?.....	☐	☐
Have you ever had braces?.....	☐	☐	Do you wear a denture or a partial?.....	☐	☐
Has fear or anxiety prevented your dental visits?	☐	☐	Do you have any loose teeth?.....	☐	☐
Do you have any broken teeth or missing fillings?.....	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐

DENTAL ROUTINE/HABITS	Yes	No		Yes	No
Do you have frequent snacks between meals?.....	☐	☐	Do you regularly drink soda, coffee or tea?.....	☐	☐
Is your home water supply fluoridated?.....	☐	☐	Do you use toothpaste with fluoride?.....	☐	☐
Do you brush twice a day for two minutes?.....	☐	☐	How often do you floss?		

How do you feel about your smile? How can we help you?

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems

MEDICAL/SURGICAL HISTORY	Yes	No	
Do you have any Heart problems?.....	☐	☐	☐Heart Attack ☐Artificial valve ☐Pacemaker ☐High Blood Pressure ☐Murmur ☐Mitral Valve Prolapse ☐Circulation problems ☐A-Fib ☐_____
Do you have any Breathing problems?.....	☐	☐	☐ Asthma ☐Persistent cough ☐Respiratory disease ☐COPD ☐Shortness of Breath ☐Tuberculosis ☐Cough up blood ☐_____
Do you have any Blood problems?.....	☐	☐	☐ HIV+/AIDS ☐Anemia ☐Hemophilia ☐Transfusion ☐ Hepatitis Type: _____ ☐_____
Do you have Ear, Eyes or Nose problems?.....	☐	☐	☐ Sinus Infections ☐Glaucoma ☐Migraines ☐Tonsillitis ☐_____
Do you have any Digestive problems?.....	☐	☐	☐ GERD ☐History of bulimia or anorexia ☐Crohn's ☐_____
Do you have any Endocrine problems?.....	☐	☐	☐ Diabetes ☐ Thyroid disorder ☐_____
Do you have any Nervous System problems?...	☐	☐	☐ Stroke ☐Epilepsy ☐_____
Do you have any Psychiatric problems?.....	☐	☐	☐ Anxiety ☐ Bipolar ☐ Depression ☐ ADD/ADHD ☐_____
Do you have other Systemic Diseases?.....	☐	☐	☐Kidney disease ☐Liver Disease ☐Jaundice ☐Rheumatic Fever ☐Scarlet Fever ☐Arthritis/Rheumatism ☐ Lupus ☐_____
Do you have a history of Cancer?..... Location:	☐	☐	☐Treatment with Radiation/Chemotherapy
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	Please describe:
Do you have other Health concerns not listed?	☐	☐	Please list:

ALLERGIES			
☐ **NO KNOWN ALLERGIES**			
☐ Aspirin	☐ Local Anesthetics	☐ Penicillin or other antibiotics	☐ Artificial Dyes
☐ Latex	☐ Metals (i.e nickel)	☐ Codeine or other narcotics	☐ Sulfates or Sulfa Drugs
☐ Environmental (Seasonal, Animals, Food) - Please list:			
☐ Other			

ARTIFICIAL JOINT REPLACEMENT	Yes	No
Have you had an orthopedic total joint replacement? Location: Date of surgery: Treating physician:	☐	☐
Has your doctor recommended antibiotics prior to a dental visit for your joint replacement?	☐	☐

BISPHOSPHONATES	Yes	No
Are you taking or scheduled to take an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐

SLEEP STUDY SCREENING	Yes	No		Yes	No
Do you snore?.....	☐	☐	Do you wake up in the night gasping for breath?	☐	☐
Have you had a sleep study?.....	☐	☐	Do you wear a CPAP or other device?.....	☐	☐

SOCIAL HISTORY	Yes	No		Yes	No
Do you use tobacco or vape? (Smoking, snuff, dip, chew)	☐	☐	Do you drink alcoholic beverages?.....	☐	☐
If so, how often during the day?			Do you use recreational drugs?	☐	☐
If so, how interested are you in stopping any of the above? VERY / SOMEWHAT / NOT					

WOMEN ONLY	Yes	No		Yes	No
Are you pregnant? ..... Number of weeks: _____	☐	☐	Are you breastfeeding or pumping?.....	☐	☐
Are you taking birth control pills or hormonal replacement?.....				☐	☐

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Are you under the care of a physician?

Physician Name:

Office Name and Location:

Please list all prescription or over the counter medications, dietary supplements and vitamins you are taking:

*If you carry a list, we can make a copy

The above information is accurate and complete to the best of my knowledge. 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.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Garrison Family Dentistry may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____
Date of Birth: _____

I. My Authorization

I authorize _____ to use or disclose the following health information:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition:

  _____
- ❑ My health information covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ❑ Other:_____

The above party may disclose this health information to the following recipient:

Name/Organization:

_____

Phone: _____ Fax: _____

Email: _____

The purpose of this authorization is (check all that apply):

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health

information and will stop any future sales if I revoke this authorization.

- ❑ Other:

_____

_____

_____

This authorization ends:

- ☐ On (Date): _____
- ☐ When I am no longer a patient of the practice.
- ☐ When the following event occurs:

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____
Date: _____

If the patient is a minor or unable to sign please complete the following:

- ❑ Patient is a minor: _____ years of age
- ❑ Patient is unable to sign because:

_____

Authorized Representative Signature: _____

Date: _____

Print Name of Representative:

_____

Authority of representative to sign on behalf of patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other:

_____

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I consent ☐ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

☐ I consent ☐ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

V. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____