MONILA REHEMAN, DMD
FAMILY DENTISTRY

Patient Registration Form

Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink only. If you have any questions regarding this form do not hesitate to ask for assistance. We will be happy to help.

(Please Print)
Patient Name: _____ Date: _____
Last Middle First
Date of Birth: _____ SS#: _____ SEX: Male Female

Marital Status: Single Married Divorced Widowed Partnered
Home Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
What is the best way to contact you? Home Cell Pager Email Work Mail
Employer/School Name: _____ Occupation: _____
Address: _____
Who may we thank for referring you? _____

RESPONSIBLE PARTY
Name of person responsible for account: _____ Relationship: _____
Date of Birth: _____ SS#:_____ Phone: _____
Address: _____
Employer Name: _____ Work Phone: _____
***Please list an Emergency Contact not living with you (Name/Phone):_____**

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Relationship: _____
Date of Birth: _____ SS#:_____
Insurance Company: _____
Group #:_____ ID #:_____
Employer's Name: _____ Phone: _____

SECONDARY DENTAL INSURANCE INFORMATION

Do you have secondary dental insurance? YES NO
Subscriber's Name: _____ Relationship: _____
Date of Birth: _____ SS#:_____
Insurance Company: _____
Group #:_____ ID #:_____
Employer's Name: _____ Phone: _____

CONFIDENTIAL

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PATIENT DENTAL & MEDICAL HISTORY

Name _____ **Date of Birth:** _____ **Date** _____
What is the most important reason for your dental visit today? _____
The most important thing about your future smile and dental health is: _____

Please Share Some Dates:
Your Last Cleaning: _____
Your Last set of X-rays:_____
Your Last Oral Cancer Screening: _____
Your Last Dental Exam: _____

On a Scale of 1-10, with 10 being the highest rating:
How important is your dental health?
1 2 3 4 5 6 7 8 9 10
Where would you rate your *current* dental health?
1 2 3 4 5 6 7 8 9 10
Where do you *want* your dental health to be?
1 2 3 4 5 6 7 8 9 10

Do any of the following problems apply to you?

Sensitivity (Hot/Cold/Sweets)	YES NO	Food Collection between Teeth	YES NO
Headaches, Ear aches, Neck pain	YES NO	Jaw joint pain, Grinding, Clenching	YES NO
Teeth or Fillings breaking	YES NO	A Bad Breath	YES NO
Bleeding, Swollen or Irritated gums	YES NO	Loose, Chipped or Shifted teeth	YES NO

Do you have/had any of the following? Dentures Partials Braces Periodontal (gum) Treatment

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Physician's Name: _____ **Phone:** _____ **Last Exam:** _____
Have you been hospitalized within the last 5 years? YES NO **If yes, reason:** _____

For the following please circle *yes* or *no*. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our staff may ask additional questions regarding your health.

Anemia or Blood Disorder	NO	YES	Hepatitis Any Form	NO	YES
Arthritis, Rheumatism or Inflammatory Disease	NO	YES	Artificial Joint Replacement Where?	NO	YES
Asthma	NO	YES	Kidney Disease	NO	YES
Abnormal Bleeding	NO	YES	Liver Disease (including Jaundice)	NO	YES
Cancer or Tumor	NO	YES	Sore/ Enlarged Lymph Nodes	NO	YES
Diabetes	NO	YES	Psychiatric Care	NO	YES
Emphysema or other Respiratory/ Lung Illness	NO	YES	Previous Biopsies	NO	YES
Epilepsy	NO	YES	Radiation or Chemotherapy Treatment	NO	YES
Fainting or Dizzy Spells	NO	YES	Rheumatic Fever	NO	YES
Glaucoma	NO	YES	Slow- Healing Mouth Sores	NO	YES
Abnormal Heart/ Previous Bacterial Endocarditis	NO	YES	Unintentional Weight Gain/ Loss	NO	YES
Heart Valve (artificial) or Heart Transplant	NO	YES	H.I.V Infection AIDS or ARC	NO	YES
Heart Disease, Heart Attack, Heart Surgery	NO	YES	Venereal Disease	NO	YES
Heart Murmur	NO	YES	Tuberculosis	NO	YES
Heart Stent Placed When?	NO	YES	Nervous Problems	NO	YES
Mitral Valve Prolapse	NO	YES	Stroke	NO	YES
Cough, Persistent	NO	YES	Pacemaker	NO	YES
Ever Coughed up Blood	NO	YES	Back Problems	NO	YES
Thyroid Problems	NO	YES	Swelling of Feet or Ankles	NO	YES
Others:					

Abnormal Blood Pressure? YES NO If yes, is it HIGH or LOW? _____
Have you ever received a diagnosis of "high blood pressure"? YES NO
If yes, are you under a doctor's care? YES NO

Women: Are you pregnant? YES NO If no, are you planning a pregnancy in the near future? YES NO
Are you a nursing mother? YES NO Are you taking birth control? YES NO

Do you Pre-Medicate before dental visits? YES NO

Have you been treated with bisphoshonate drugs (Fosamax, Aredia, Zometa, Actonel, and Boniva)? YES NO
If so, when did the treatment start: _____

Please list any medications or dietary/herbal supplements you are currently taking and for what purpose:

1._____ **2**._____
3._____ **4**._____
5._____ **6**._____

Are you allergic or have reactions to:

Local Anesthetics	NO	YES	Codeine, Valium or other sedatives	NO	YES
Penicillin or other antibiotics	NO	YES	Latex	NO	YES
Aspirin, Ibuprofen, Tylenol	NO	YES	Metals	NO	YES
Other (Please Specify)					

Do you consume alcohol? YES NO If yes, approximately how much per week? _____
Do you use any mood altering drugs other than those previously listed? YES NO

Certification and Assignment

To the best of my knowledge the above information is complete and correct. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I certify that I and my dependant(s), have insurance coverage with _____and assign directly to Dr. Monila Reheman, DMD all insurance 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 authorize the use of my signature on all insurance claims. The above-named doctor and facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hearby authorize Dr. Monila Reheman to take study models, X-rays, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Monila Reheman to perform any and all forms of treatment, medication, and therapy that may be indicated, I also understand that the use of anesthetic agents embodies a certain risk.

Financial Policy

By signing below you are stating you understand the following: Payment is due at the time services are rendered. Our office accepts cash, personal checks, MasterCard, Visa, American Express, Discover and Care credit. Our office also offers outside financing upon request and approval please ask for further details. You authorize this office to obtain a copy of your credit report from a credit reporting agency for the purpose of considering payment options. As a courtesy to our insured patients, we will gladly file your dental claims for services rendered. Please understand that we are only given an estimate for your dental care therefore we can only pass the estimate on to you, the patient. After your insurance pays their portion there may still be an amount due. This amount will be your responsibility and will be sent to you in the form of a statement. Please understand that we will do our best to get your insurance to pay for all work performed by our office, however most insurance plans only pay for a portion of dental services. Please understand that if after 60 days there has been no payment made it is your responsibility to follow up with your insurance and retain payment.

Signature: _____ Date: _____
Patient, Parent, Guardian, or Personal Representative
Doctor's Signature: _____ Date: _____

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HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Dr. Monila Reheman to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online services)

I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Dr. Monila Reheman reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this on _____ day of _____, 20____.

Name Printed: _____

Signature: _____

Relationship to patient: _____

Dr. Monila Reheman, DMD
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