LARAMIE RIVER Dental

Patient Registration

Patient Name:

Last *First* *Mi* *Preferred Name*

Gender: M F Other **Family Status:** Married Single Child

Please circle the phone number below that is your preferred contact method.

Birth Date *Mobile #* *Home #* *Work #* *Email*

Mailing Address *City* State Zip

Emergency Contact:

Last *First* *Phone #* *Relation*

Responsible Party Information *(Party responsible for patient, if other than patient)*

Name:

Last *First* *Mi* *Birth Date* *Email*

Mailing Address *City* *St* *Zip* *Mobile #* *Home #* *Work #*

Employer:

Name *Mailing Address* *City* *State* *Zip* *Phone #*

Insurance Information: (Please alert the front desk if you have an insurance card to put on file.)

Primary Insurance:

Name *Claims Mailing Address* *City* *State* *Zip* *Phone #*
(Usually found on back of Insurance Card)

Name of Policy Holder(the insured):

Last *First* *Birth Date*

Mailing Address *City* *State* *Zip* *Phone #*

Policy/Subscriber ID #: **Group Name or Number:**
(If not on insurance card, it's most likely your social security number)

Secondary Insurance:

Name *Claims Mailing Address* *City* *State* *Zip* *Phone #*
(Usually found on back of Insurance Card)

Name of Policy Holder(the insured):

Last *First* *Birth Date*

Mailing Address *City* *State* *Zip* *Phone #*

Policy/Subscriber ID #: **Group Name or Number:**
(If not on insurance card, it's most likely your social security number)

How did you hear about us?

- ☐ Referal by _____
- ☐ Search Engine (Google, Yahoo, etc.)
- ☐ Facebook
- ☐ Instagram
- ☐ Other: _____

Permission to Share Health Information

I, _____ give Laramie River Dental permission to share my health/dental information with the following:

Contact Name _____

Relationship _____

Contact Number _____

Contact Name _____

Relationship _____

Contact Number _____

Acknowledgement of Receipt of Notice of Privacy Practices

"You May Refuse to Sign This Acknowledgement"

I, _____, have been offered, received, or had made available to me a copy of this office's Notice of Privacy Practices.

_____

Signature **Date**

_____

Parent/Legal Guardian Signature **Date**

Please ask the front desk for a copy if you would like a copy.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Authorization to Access Electronic Medical History Files

"You May Refuse to Sign This Acknowledgement"

Disclaimer: Certain information may not be available or accurate in this report, including items that the you asked your provider not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for out of pocket, or non-participating sources, or errors in insurance claims information. Laramie River Dental will still independently verify medication history.

I, _____ Give consent for Laramie River Dental to retrieve my medical history information via the Electronic e-prescription portal

_____

Signature **Date**

_____

Parent/Legal Guardian Signature **Date**

LARAMIE RIVER Dental

Medical History

General Questions

Primary Physician's Name _____ **Practice Name** _____

Date of Last Physical _____ Please list current medications below:

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

If you need to list more, please write them on the back of this sheet of paper and indicate it by **Circling Here.**

Do you have any allergies? If yes, please list and describe the reaction that occurred _____

_____

Has there been any changes in your health history over the last year? If yes, please explain _____

For Yes/No questions, please circle yes or no.

Head and Neck

Have you ever had a serious injury to the head or neck area? **Yes / No**

If Yes, please explain _____

Have you had any surgeries to the head or neck area? **Yes / No**

If Yes, please explain _____

Cardiovascular

Do you have a prosthetic cardiac valve?	**Yes / No**	Do you have a congenital heart disease?	**Yes / No**
Do you have a history of infective endocarditis?	**Yes / No**	Do you have a pacemaker?	**Yes / No**
Do you have a history of cardiovascular disease?	**Yes / No**	Do you have high blood pressure?	**Yes / No**
Have you ever had abnormal bleeding after surgery?	**Yes / No**	Do you bruise easily?	**Yes / No**
Have you ever been diagnosed with a bleeding disorder?			**Yes / No**
Has it been recommended that you take an antibiotic premedication prior to dental procedures?			**Yes / No**

Any other heart conditions we should be aware of: _____

If you are under the care of a cardiologist, please provide their name and contact information:

_____

Blood Born Diseases

Have you ever been diagnosed with HIV? **Yes / No**

Have you ever been diagnosed with Hepatitis? **Yes / No**

If Yes, please circle if it was Hep A, Hep B, Hep C, or Hep D

Diabetes

Have you been diagnosed as prediabetic? **Yes / No**

Are you diabetic? **Yes / No**

If Yes, Type 1 or Type 2? _____

If Yes, what was your last A1C_____ **Date it was last taken:** _____

Skeletal

Have you ever had a spine or neck injury? **Yes / No** Do you have osteoarthritis? **Yes / No**
Do you have multiple sclerosis? **Yes / No**
Have you had a joint replacement? **Yes / No**
If Yes, what joint/joints?_____ When was the surgery done?_____
If Yes, did your orthopedic surgeon prescribe you an antibiotic premedication prior to dental procedures? Yes/No
If Yes, please provide the contact information for your orthopedic surgeon: _____
Any other bone disorder we should be aware of: _____

Bisphosphonate Use

Bisphosphonates are often prescribed for treatment of bone conditions like osteoporosis.
Bisphosphonates are occasionally prescribed as an addition to certain kinds chemotherapy treatment.

Have you ever taken a bisphosphonate (examples: Fosamax, Boniva, Zometa, Reclast, Actonel, Altevia)? **Yes / No**
If Yes, how long have you/were you on the bisphosphonate? _____
If you have discontinued use, when was your last dose? _____

Cancer

Have you ever been diagnosed with cancer? **Yes / No**
If Yes, What kind of cancer? _____ When was the diagnosis?_____
If Yes, Did you have chemotherapy and or radiation as part of the cancer treatment? _____
If Yes, When was your last treatment? _____

Breathing/Lungs

Have you ever had tuberculosis? **Yes / No** Have you ever been told that you snore? **Yes / No**
Do you have asthma? **Yes / No**
If Yes, do you currently use an inhaler? _____
Have you ever been diagnosed with sleep apnea? **Yes / No**
If Yes, Do you use oxygen, CPAP or other breathing device at night? _____
Any other breathing concerns we should be aware of: _____

Gastroenterology

Do you have gastric reflux? **Yes / No** Do you have liver disease? **Yes / No**
Do you have kidney disease? **Yes / No** Are you undergoing dialysis? **Yes / No**
Have you had a organ transplant? **Yes / No** Are you immune compromised? **Yes / No**
Do you have Crohn's disease or inflammatory bowel disease? **Yes / No**

Nervous System and Mental Heath

Have you ever been diagnosed with depression? **Yes / No** Do you have memory loss? **Yes / No**
Have you been diagnosed with a learning disability? **Yes / No** Do you have epilepsy or seizures? **Yes / No**
Do you have reduced fine motor function (i.e. holding or using a toothbrush)? **Yes / No**
Have you been diagnosed with a nervous system disorder? **Yes / No**
If Yes, Please describe. _____
Any other Nervous System of Mental Health concerns we should be aware of: _____

Substance Use

Have you ever smoked cigarettes? **Yes / No**
If Yes, how many per day and for how long? _____
Have you ever used smokeless tobacco? **Yes / No** Do you smoke a pipe? **Yes / No**
Do you use an E-vape? **Yes / No** Do you smoke marijuana? **Yes / No**
Do you have a history of substance abuse? **Yes / No**
If Yes, please list: _____

For Women

Are you pregnant? **Yes / No** Are you breastfeeding? **Yes / No**
If Yes, how many weeks?_____

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No Show/Late Cancellation Appointment Policy

The Laramie River Dental team understands that sometimes you need to cancel or reschedule your appointment and that emergencies happen. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24 hour notice).

To ensure that we are able to provide every patient with the highest quality of care, it is important that patients arrive on time for their dental visits and are scheduled for the proper appointment length. As a courtesy, we will call/text you prior to your scheduled appointment. We acknowledge that it is our responsibility to inform patients of any necessary schedule changes as far in advance as possible. It is the responsibility of the patient to arrive for their appointment on time so that we are able to uphold the highest standard of dental care.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hour notice. There is a waiting list to see the clinicians at Laramie River Dental and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If you do not show up for your appointment, this will be documented as a “No Show” appointment.

3. If less than a 24 hour cancellation is given, this will be documented as a “Late Cancellation” appointment.

4. After the first “No Show/Late Cancellation” appointment, you will receive a letter to inform/remind you of our "No Show/Late Cancellation" policy. Laramie River Dental will assist you to reschedule this appointment as needed.

5. After the second “No Show/Late Cancellation” appointment, you will be asked to give the office a $50 reservation deposit in order to schedule any future appointments. This deposit will be put towards the cost of the appointment it was deposited for. If it becomes a “No Show/Late Cancellation” appointment, your deposit will be forfeited and will NOT be refunded or put towards future appointment costs.

6. After the third “No Show/Late Cancellation” appointment, dismissal from the practice may be considered.

_____ _____

Signature Date