



CONFIDENTIAL PATIENT REGISTRATION

PATIENT'S NAME

Last _____ First _____ Middle Initial _____

Name you prefer to be called _____ SEX: M F Birthdate _____

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

RESPONSIBLE PARTY INFORMATION

Last _____ First _____ Middle Initial _____

Relationship to Patient _____ Soc. Sec. # _____

SEX: M F Birthdate _____

ADDRESS: Street _____ apt# _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

DENTAL INSURANCE INFORMATION

Insured's Name _____

Insured's Birthdate _____ Soc. Sec. # _____

Insurance Company _____ Insured's Employer _____

Subscriber# _____

EMERGENCY CONTACT INFORMATION

Name _____

Phone _____

Email _____

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ Date of most recent x-rays _____
Date of most recent treatment (other than a cleaning) _____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely
What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: _____ **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed? _____

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____
8. Have you ever whitened (bleached) your teeth? _____
9. Are you self conscious about your teeth? _____
10. Have you been disappointed with the appearance of previous dental work? _____

BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum? _____
12. Do you / would you have any problems chewing bagels or other hard foods? _____
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
14. Are your teeth crowding or developing spaces? _____
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
18. Do you have tension headaches or sore teeth? _____
19. Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____
21. Do you have a dry mouth? _____
22. Are any teeth sensitive to hot, cold, biting or sweets? _____
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____
24. Do you avoid brushing any part of your mouth? _____
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____
27. Have you ever experienced gum recession? _____
28. Is there anyone with a history of periodontal disease in your family? _____
29. Do your gums bleed when brushing, flossing or eating? _____
30. Are your teeth becoming loose? _____
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____
32. Have you experienced a burning sensation in your mouth? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO		YES	NO
1. Hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			26. osteoporosis/osteopenia _____		
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			(i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			32. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	37. hepatitis (type ____) _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management _____		
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	(i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
			56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
			57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Doctor's Signature _____



NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Dr. Hahn's office. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office - we are not required to grant the request but we will comply with any request granted.
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
3. Right to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide you upon request. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If you request copies, we may charge a small fee. If you request an alternative format, we will charge a cost based fee for providing your health information in that format.
4. Right to appeal a denial of access to your protected health information, except in certain circumstances.
5. You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) Dr. Hahn is not required to make such amendments. You may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
6. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
7. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide you upon request. If you want to exercise any of the above rights, please contact Anita Alexander, 703-444-4441, 20789 Great Falls Plaza, Suite 104, Potomac Falls, VA 20165, in person or in writing.

Our Responsibilities

Our office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice", by visiting our office and picking up a copy, or by downloading the revised copy from our website at www.hahndentistry.com.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Anita Alexander, 703-444-4441, 20789 Great Falls Plaza, Suite 104, Potomac Falls, VA 20165. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Anita Alexander. You also may submit a written complaint to the U.S. Department of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office. We cannot, and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.



**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this agreement.

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)
