



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 _____

Street Address _____ 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 _____

Referred by _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____

(Mos/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) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | |
|--|--------------------------|--------------------------|
| 7. Is there anything about the appearance of your teeth that you would like to change? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you self conscious about your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

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

TOOTH STRUCTURE

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

GUM AND BONE

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

Patient's Signature Date

Doctor's Signature Date

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	DO YOU HAVE or HAVE YOU EVER HAD:	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 (i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
aspirin, ibuprofen, acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>	27. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
penicillin	<input type="checkbox"/>	<input type="checkbox"/>	28. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	29. Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	30. Head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
codeine	<input type="checkbox"/>	<input type="checkbox"/>	31. Epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	32. Neurologic problems	<input type="checkbox"/>	<input type="checkbox"/>
fluoride	<input type="checkbox"/>	<input type="checkbox"/>	33. Viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
metals (gold, stainless steel)	<input type="checkbox"/>	<input type="checkbox"/>	34. Any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
latex	<input type="checkbox"/>	<input type="checkbox"/>	35. Hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
any other medications	<input type="checkbox"/>	<input type="checkbox"/>	36. Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	37. Hepatitis (type ____)	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
5. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	39. Tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
6. Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	40. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
7. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	41. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
8. Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	42. Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
9. A stroke	<input type="checkbox"/>	<input type="checkbox"/>	43. Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
10. Artificial prosthesis (i.e. heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	44. Antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
11. Anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	45. Alcohol / drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
12. Prolonged bleeding due to a slight cut	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	46. Presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>
14. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	47. Aware of a change in your general health	<input type="checkbox"/>	<input type="checkbox"/>
15. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	48. Taking medication for weight management (i.e. fen-phen)	<input type="checkbox"/>	<input type="checkbox"/>
16. Breathing or sleep problems (i.e. snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	49. Taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>
17. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	50. Often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
18. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	51. Subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
19. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	52. A smoker or smoked previously	<input type="checkbox"/>	<input type="checkbox"/>
20. Thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	53. Considered a touchy person	<input type="checkbox"/>	<input type="checkbox"/>
21. Hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	54. Often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
22. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
23. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant	<input type="checkbox"/>	<input type="checkbox"/>
24. Stomach or duodenal ulcer	<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
_____	_____
_____	_____
_____	_____
_____	_____

Please advise us of any future changes in your medical history or medications you may be taking.

Patient's Signature

Doctor's Signature



DENTISTRY

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.

Raymond C. Hahn, DDS

20789 Great Falls Plaza

Suite 104

Potomac Falls, VA 20165

info@lowesislanddentistry.com

lowesislanddentistry.com

phone 703.444.4441

fax 703.444.8577



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)

