DIANA L. O'QUINN, D.D.S.
DENTAL REGISTRATION AND HISTORY

Patient Information

Date _____

Name _____

Address _____

City/St/Zip_____

Hm # _____ Wk # _____

Cell # _____ ____

Social Security # _____

Birthdate _____Age _____

Married _____ Single_____

Employer _____ _____

Occupation _____

E-mail Address _____

_____

Spouse's Name _____

Birthdate _____Age_____

Spouse's Employer _____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

Dental Insurance

Insurance Co. _____

Subscriber's Name _____

Relationship to patient? _____

Birthdate _____ SS # _____

Group No. _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of ins. co.

And assign directly to **Dr. O'Quinn** 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 submissions.

Dr. O'Quinn may use my health care information and may disclose such information to the above named insurance company and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of patient or person responsible

_____ _____
Date Relationship to patient

Dental History

Reason for today's visit _____

Date of last dental visit _____ What concerns do you have regarding your teeth?_____

Have you ever had complications following dental treatment? _____

If you could change anything about your smile, what would it be? _____

Please indicate if you have done or are interested in:

_____ Bonding _____ Veneers _____ Invisalign
_____ Botox _____ Dermal Fillers (Juvederm) _____ Laser whitening (ZOOM)
_____ Whitening Trays _____ Other whitening procedures

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Medical History

Physician's Name _____ Date of last visit _____
Phone _____ Pharmacy _____ Phone number _____

Please check to indicate if you have or have had any of the following:

___ Aids
___ Anemia
___ Arthritis, Rheumatism
___ Asthma
___ Back pain
___ Cancer
___ Chemical dependency
___ Chemotherapy
___ Circulatory problems
___ Cough, persistent
___ Diabetes
___ Emphysema
___ Epilepsy
___ Excessive bleeding
___ Fainting or dizziness
___ Glaucoma
___ Heart disease
___ Hepatitis
___ High blood pressure
___ HIV positive
___ Jaundice
___ Jaw pain
___ Kidney disease
___ Liver disease
___ Low blood pressure
___ Nervous problems
___ Psychiatric care
___ Radiation treatment
___ Respiratory disease
___ Shortness of breath
___ Sinus trouble
___ Stroke
___ Stomach problems
___ Thyroid problems
___ Heart murmur
___ Herpes
___ Tonsillitis
___ Tuberculosis
___ Tumors or growths
___ Ulcer
___ Venereal disease
___ Pregnancy
Due date _____

Have you ever had or been diagnosed with

___ Artificial heart valves
___ Artificial joints, screws, pins, etc.
___ Bleeding abnormally
___ Blood disease
___ Heart Murmur
___ Mitral Valve Prolapse
___ Pacemaker
___ Rheumatic Fever

MEDICATIONS
Please list all medications you are taking

_____
_____

ALLERGIES
Please list any allergies

_____
_____

Signatures

Certification

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have any changes in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please print name of minor/child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child names above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the Doctor whether or not I am present when the treatment is rendered.

Authorization to Release Protected Health Information

I understand that there may be a need to consult with other health care providers. I voluntary authorize **Dr. O'Quinn** to use and/or disclose my Protected Health Information (PHI) related to my dental treatment, payment activities and healthcare operations. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the **Office Manager**.

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. **I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my Insurance company does not relieve me from my responsibility.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**