Please complete our confidential patient registration forms with your keyboard and mouse. Please print, sign, and then mail, fax or bring the forms with you to your next appointment. Our mailing address is Brian Zuerlein, DDS, 10110 Nicholas Street, Omaha NE 68114 and our fax number is (402) 393-4403.

PATIENT REGISTRATION

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder Preferred Name: ______

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc. Sec: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Employer ID: ______ Pref. Dentist: ______

Carrier I D: ______ Pref. Pharmacy: ______

Pref. Hyg.: ______

Section 3

REFERRED BY?:

______

Primary Insurance Information

Name of Insured: ______ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2- ______

City, State, Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2- ______

City, State, Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Health History Form

Date ______________________

Patient Name ____ Dr. ____________________________________

Occupation ____ Height ____________ Weight ____________

Date of Birth_____/_____/_____ Sex: ❑ M ❑ F

Emergency Contact ______________________________ Relationship ______________ Phone (   ) ____________

If you are completing this form for another person, what is your relationship to that person?:

Name ____ Relationship _____________________________

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your Initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This Information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know	
❑	❑	❑	Do you feel you may have bad breath at times?
❑	❑	❑	Do your gums bleed when you brush?
❑	❑	❑	Are your teeth sensitive to cold, hot, sweets or pressure?
❑	❑	❑	Have you had periodontal (gum) treatments?
❑	❑	❑	Do you occasionally have, an unpleasant taste in your mouth?
❑	❑	❑	Have you ever had orthodontic (braces) treatment?
❑	❑	❑	Do you have headaches, earaches or neck pains?
❑	❑	❑	Do you wear removable dental appliances?
❑	❑	❑	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain:

____

How would you describe you current dental problem?

____
____
____

Date of your last dental exam ____________________ Date of last dental x-rays ____________________

What was done at that time?

____
____
____

How do you feel about the appearance of your teeth?

____
____
____

Medical Information

Yes No Don't Know

❑ ❑ ❑ Are you in good health?
❑ ❑ ❑ Have there been any changes in your general health within the past year? If so, explain:

____

Do you have any of the following diseases or problems:

❑ ❑ ❑ Active Tuberculosis
❑ ❑ ❑ Persistent cough greater than a 3 week duration
❑ ❑ ❑ Cough that produces blood,

❑ ❑ ❑ Are you now under the care of a physician? If so, what is/are the condition(s) being treated?
________________________ Date of last physical examination ____________

Physician(s) ____
NAME PHONE ADDRESS CITY/STATE/ZIP

____
NAME PHONE ADDRESS CITY/STATE/ZIP

❑ ❑ ❑ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? ________________________

❑ ❑ ❑ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?
Prescribed ________________________
Over the counter ________________________
Natural or herbal preparations ________________________

❑ ❑ ❑ Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (desphenfluramine) or phen-fen (phentermine)? ________________________
❑ ❑ ❑ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ❑Yes ❑ No
❑ ❑ ❑ Do you use drugs or other substances or recreational purposes? If yes, please list

____
Frequency of use (daily, weekly, etc.) ____________Number of years of recreational drug use __________
❑ ❑ ❑ Do you Use tobacco (smoking, snuff, chew)? If so how interested are you in stopping?
(Check one) ❑Very ❑ Somewhat ❑ Not interested
❑ ❑ ❑ Do you wear contact lenses?

Allergies **Are you allergic to or have you had a reaction to:**

Yes No Don't Know

❑ ❑ ❑ Local anesthetics
❑ ❑ ❑ Aspirin
❑ ❑ ❑ Penicillin or other antibiotics
❑ ❑ ❑ Barbiturates, sedatives, or sleeping pills
❑ ❑ ❑ Sulfa drugs
❑ ❑ ❑ Codeine or other narcotics
❑ ❑ ❑ Latex
❑ ❑ ❑ Iodine
❑ ❑ ❑ Hay fever/seasonal
❑ ❑ ❑ Animals
❑ ❑ ❑ Food (specify)
❑ ❑ ❑ Other Specify)

To yes responses, specify type of reaction

____
____
____

Patient Name ______________________________

Dr. ______________________________

Yes No Don't Know

❑ ❑ ❑ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? ______________________________

❑ ❑ ❑ Have you had any complications or difficulties with your prosthetic joint?

❑ ❑ ❑ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?______________________________

Name of physician or dentist ______________________________ Phone ______________________________

Please (X) if you have or had any of the following diseases or problems:

Yes No Don't Know

❑ ❑ ❑ Abnormal bleeding
❑ ❑ ❑ AIDS or HIV infection
❑ ❑ ❑ Anemia
❑ ❑ ❑ Arthritis
❑ ❑ ❑ Rheumatoid arthritis
❑ ❑ ❑ Asthma
❑ ❑ ❑ Blood transfusion
If yes, date ____________________

❑ ❑ ❑ Cardiovascular disease
If yes, specify below

❑ Angina
❑ Arteriosclerosis
❑ Artificial heart valves
❑ Coronary insufficiency
❑ Coronary occlusion
❑ Damaged heart valves
❑ Heart attack
❑ Heart murmur
❑ High blood pressure
❑ Inborn heart defects
❑ Mitral valve prolapse
❑ Pacemaker
❑ Rheumatic heart disease
❑ Chest pain upon exertion
❑ Chronic pain
❑ Persistent diarrhea

❑ ❑ ❑ Disease, drug or radiation induced immunosuppression
Diabetes, If yes specify below:.
❑ Type I (insulin dependent)
❑ Type II

❑ ❑ ❑ Dry Mouth
❑ ❑ ❑ Eating disorder.
If yes, specify ____________________
❑ ❑ ❑ Epilepsy
❑ ❑ ❑ Fainting spells or seizures
❑ ❑ ❑ G E. reflux

Yes No Don't Know

❑ ❑ ❑ Glaucoma
❑ ❑ ❑ Hemophilia
❑ ❑ ❑ Hepatitis, jaundice or liver disease
❑ ❑ ❑ Recurrent infections, Indicate type of infection____________________
❑ ❑ ❑ Kidney problems
❑ ❑ ❑ Low blood pressure
❑ ❑ ❑ Mental health disorders.
If yes, specify
____
____

❑ ❑ ❑ Malnutrition
❑ ❑ ❑ Migraines
❑ ❑ ❑ Night sweats
❑ ❑ ❑ Neurological disorders
If yes, specify
____
____

❑ ❑ ❑ Osteoporosis
❑ ❑ ❑ Persistent swollen glands in neck
❑ ❑ ❑ Respiratory problems
If yes, specify below
❑ Emphysema
❑ Bronchitis, etc.

❑ ❑ ❑ Severe headaches
❑ ❑ ❑ Severe or rapid weight loss
❑ ❑ ❑ Sexually transmitted disease
❑ ❑ ❑ Sinus trouble
❑ ❑ ❑ Sleep disorder
❑ ❑ ❑ Sores or ulcers in the mouth
❑ ❑ ❑ Stroke
❑ ❑ ❑ Systemic lupus erythernatosus
❑ ❑ ❑ Thyroid problems
❑ ❑ ❑ Tuberculosis
❑ ❑ ❑ Ulcers
❑ ❑ ❑ Excessive urination
❑ ❑ ❑ Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:
____
____
____
____

(Women Only)

Yes No Don't Know

- ❑ ❑ ❑ Are you pregnant?
- ❑ ❑ ❑ Nursing?
- ❑ ❑ ❑ Taking birth control pills?

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_______________________________________ _______________

Signature of Patient /Legal Guardian Date

For completion by Dr. Zuerlein

Comments on patient interview concerning health history

____

____

____

Significant findings from questionnaire or oral interview

____

____

____

Dental management considerations

____

____

____

____

Signature of Dentist Date

Patient Name ____

Dr. ____

Consent to Examination

We are committed to doing our very best for you. This begins with understanding your dental needs and goals, and is followed by a thorough and complete dental exam, a thoroughly documented dental record, and diagnosis. This is the foundation on which all services provided are based.

Please let my signature below evidence my consent to your dental examination. As a part of that examination, I understand that you and your staff may take x-rays, study models, photographs, and perform other diagnostic procedures which you deem appropriate to make a thorough diagnosis of my dental condition and needs.

I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used, and the risks involved however slight. I believe that I have sufficient information to give you my consent.

____ Patients Signature

____________________ Date

Consent to Release or Review Dental Information/Records

All patients have the right to expect that all communications and records pertaining to their care should be treated as confidential.

So that you may make a thorough examination and diagnosis, I also understand that you may need to. obtain information from my medical doctor and/or my prior dentist(s). Therefore, I grant you the right to obtain information about my health condition from my medical doctors and other dentists.

I also give you permission to share my health information with other health care professionals and dental specialists which would include the release of my dental charts and record for the sole purpose of consultation regarding diagnosis, treatment planning, and care.

I also give permission to an authorized auditor who may review the record as part of a general survey of patient care to assure standards of high quality and service.

____ Patients Signature

____________________ Date