QUAKER CITY DENTAL
Conover | Hoffman | Lam

1015 Chestnut St, Suite 1117
Philadelphia, PA 19107

office@quakercitydental.com
215.923.3999

PATIENT REGISTRATION

Today's date:

Name: Dr/Mr/Mrs/Ms ☐ Male ☐ Female

Address: City: State: Zip:

DOB: SS#:

Home phone: Work: Cell:

Email:

Whom may we thank for referring you to us? Relationship to you:

List any other family members who come to our office?

Person to contact in case of an emergency: Phone:

Person financially responsible: Relationship to you:

Address: City: State: Zip:

Home phone: Work: Cell:

Dental Insurance Information

Insurance company:

Who is the insurance through? ☐ Self ☐ Spouse

Spouse full name: Spouse DOB:

Subscriber/Member ID#: Group#:

Employer: (Please provide insurance card)

Dental History

Are you presently in any discomfort? ☐ Yes ☐ No If yes, describe:

Do you have any dental fears? ☐ Yes ☐ No If yes, describe:

Are you dissatisfied with your teeth & their appearance?

How often do you brush your teeth?

How often do you floss your teeth?

Does anyone in your family have gum disease? ☐ Yes ☐ No

Do your gums bleed when you brush? ☐ Yes ☐ No

Do you have swelling around any teeth? ☐ Yes ☐ No

Do you notice a bad taste or odor? ☐ Yes ☐ No

Are your teeth sensitive to (check all that apply) ☐ Hot ☐ Cold ☐ Sweet ☐ Biting pressure

Have you noticed any jaw problems like: ☐ Clicking ☐ Pain ☐ Chewing ☐ Opening ☐ Closing

Are you concerned about the finances required to return your teeth to excellent dental health? ☐ Yes ☐ No

Do you get frustrated because you always need something to be treated or repaired at the dentist? ☐ Yes ☐ No

Why did you leave your last dentist?

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MEDICAL HISTORY

Physician's name: Phone:

Date of your last physical exam?

Please list current medications

Do you require pre-medication prior to dental appointments? ☐ Yes ☐ No

If yes, please list and for what condition?

Do you have any allergies to medications? ☐ Yes ☐ No If yes, describe:

Have you been a patient in a hospital in the past five years? ☐ Yes ☐ No If yes, describe:

Have you ever had any surgeries? ☐ Yes ☐ No If yes, describe:

Have you had or do you have any of the following:

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No
Heart Pacemaker/ Defibrillator	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Stroke / TIA	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
History of Endocarditis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Artificial Joints (hip, knee etc.)	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Arthritis/Rheumatism or swelling of joints	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No
Bone Density Drugs, Osteoporosis	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No	Radiation Therapy, Chemotherapy	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Cancer, Tumor	☐ Yes	☐ No
AIDS,HIV	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Hemophilia, Bleeding problems	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Dizziness, Fainting, Vertigo	☐ Yes	☐ No
Hepatitis A, B, or C	☐ Yes	☐ No	Cosmetic Surgery	☐ Yes	☐ No
Women Only: Are you pregnant?	☐ Yes	☐ No	If yes, Due date?		
Women Only: Are you taking birth control pills?		☐ Yes	☐ No		

Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No

Please explain:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any change in my health or medication.

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon myself and to employ such assistance as required to provide proper care.

Signature: Date:

Witness:

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Quaker City Dental / Dr. Conover and his associates may use or disclose your health care information.

The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though this office has taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice.

Signing below indicates that you have received the Notice of privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer.

I hereby acknowledge that I have received a copy of the Office's Notice of Privacy Practices.

Signature: _____ Date: _____

Name (Please Print): _____

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. Date: _____

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (specify below)

_____

_____

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PERMISSION TO SEND X-RAYS AND CORRESPONDENCE VIA EMAIL

I consent to the use of email for transmission of my x-rays and letters of correspondence to my personal email address as well as other dental offices (including referrals for specialty care).

This form will remain in effect until otherwise noted (via email or in person).

NOTE: Like any method of communication, there is some risk that information sent via email could be read or accessed by a third party in transit. The practice has adopted reasonable safeguards (password protection and individual user IDs) to minimize this risk.

Signature: _____

Patient Name: _____ Date: _____