Michael R. Nugent, D.D.S., P.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY

In order to for Dr. Nugent and his staff to better assist you with your Oral Health, please complete the following questions.

Patient Name_____ **Today's Date**_____

What is your reason for today's visit?

___ Complete Exam w/ Cleaning ___ Emergency Exam ___ Veneers/Crown/Bridge
___ Implants ___ Grinding/TMJ ___ Bleeding Gums
___ Partial/Dentures ___ Extractions ___ Dental Sedation
___ Tooth Colored Fillings ___ Bleaching Other _____

Have you needed to be **Pre-medicated** before any dental treatment in the past? **No / Yes**
If so, for what reason? ___ Hip/Knee Replacement _____Year ___ Heart Problems _____Year
Other_____Year_____ Physician Name & Ph# _____

Are you having any dental pain? YES / NO If so, how long has it been bothering you? _____

Last Dental Exam? _____ Last Cleaning? Months: 3 / 4 / 6 / 12 Years: _____ or 1st Time

Last Full Set of X-Rays Taken_____ How often do you brush your teeth? _____

What type of toothbrush do you use? Manual / Electric Brand_____

Do you floss? Yes/No; How Often _____ Have you had Oral Cancer Screening before? Yes/No/Not Sure

Have you ever been diagnosed with Gum or Periodontal Disease? No / Yes How long ago?_____

Are you happy with your Teeth/Smile Yes / No If not, what areas are of concern? _____

Are you interested in information on a whiter smile? Yes / No

Check any of the following which apply now or in the past:

___ Hot or Cold Sensitivity ___ Sweets Sensitivity ___ Biting or Chewing Sensitivity
___ Experience Bad Breath ___ Smoke/Chew Tobacco ___ Used a Night or Bite Guard
___ Bleeding/Painful Gums ___ Oral or Gum Surgery ___ Clench or Grind awake/sleeping
___ Lip/Tongue Piercing ___ Loose Teeth ___ Jaw Sore or Clicking/Popping
___ Pain (Joint, side of face) ___ Difficulty Chewing ___ Frequent Cold Sores or Blisters
___ Head/Neck Injury ___ Braces, When____ ___ Fixed/Removable Retainer

Do you feel nervous about Dental Treatment? No / Yes Have you had a bad dental Experience? No / Yes
If so, please describe _____

What is your biggest concern? _____
Is there anything else you would like us to know? Please describe_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.
*Signature of Patient/Guardian*_____ Date _____

DR. MICHAEL NUGENT D.D.S.

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid
Preferred Name:	Birth Date: / /	Sex: ❑ M ❑ F	Social Security #:		Home/Cell #: ( )
Street Address:			Email:		Work #: ( )
City/State:	ZIP Code:		Employer:		Cell/Alt #: ( )
Referred by (please check one box):	❑ Family	❑ Friend	❑ Google/Internet	❑ Close to home/work	❑ Dr
Other family members seen here:					

RESPONSIBLE PARTY INFORMATION

Last Name:	First:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid
Birth Date: / /	Sex: ❑ M ❑ F	Social Security #:	Relation to Patient: ❑ Self	❑ Spouse ❑ Child ❑ Other	Home/Cell #: ( )
Street Address:			Email:		Work #: ( )
City/State:	ZIP Code:		Employer:		Cell/Alt #: ( )

DENTAL INSURANCE INFORMATION

(A copy of a photo ID and **Dental** Insurance card is required to file claims. Please give these to the receptionist.)

Policy Holder's Name:	Address (if different):	Home phone #: ( )
Employer Name:	Name of **Primary Dental** Insurance:	

Policy Holder's S.S. #:	Birth Date: / /	Member/Subscriber ID#:	Group #:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other
Name of **Secondary Dental** Insurance(if applicable):	Subscriber's name:			Employer Name:
Policy Holder's S.S. #:	Birth Date: / /	Member/Subscriber ID#:	Group #:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relation to patient:	Home/Cell #: ( )	Work/Alt: ( )

OFFICE POLICIES

We greatly appreciate your efforts in honoring scheduled appointments and wish to provide all of our patients with the highest quality dental care in the most reasonable time possible. We request at least a 48 hour notice before cancelling or rescheduling an appointment. ***If a patient FAILS or CANCELS two (2) scheduled appointments WITHOUT 48 hours advance notice, we will institute a Same Day Cancellation/Broken Appointment Fee of $50.00.***

I understand and agree to the above information and acknowledge that the entire fee is my responsibility regardless of any action taken by my insurance carrier. I understand that benefits not paid in 60 days will be my responsibility. I authorize insurance benefits to be paid directly to Dr. Michael R. Nugent. If my insurance carrier sends me reimbursement instead of sending it directly to Dr Nugent, I realize this payment is due him and I will pay immediately. I authorize Dr. Nugent or my insurance company to release any information required to process my dental claims.

Patient/Guardian signature *Date*

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and is disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of_____ , 20___ .

Printed Patient Name: _____

Relationship to Patient: _____

Signature: _____