Bush & Howard Dental Office
Patient Registration

Date:_____ Home Phone#_____

Patient:_____ Work Phone#_____

Cell Phone#:_____

Preferred Name:_____ Email:_____

Mailing Address:_____
City: _____ State:_____ Zip:_____

Sex: Male/Female Age:_____ Birth Date:_____
If married, Spouse's Name:_____

Employed By:_____Business Address:_____

Who is responsible for this account?_____
Relationship to Patient:_____

Dental Insurance Company:_____ Group#:_____
Plan ID# or social security #:_____

In case of emergency, who should be notified?:_____

What is the name and location of the pharmacy you use for prescriptions?:

-Pharmacy name : _____

-Pharmacy address: _____

Bush & Howard Dental - Patient Medical History

Patient Name: _____
Date of Birth: _____
Physician's (Medical Doctors) name: _____
Physician Office Location: _____
Are you under medical care now?_____ If yes for what?_____

Please list all Medications, drugs, herbs, or pills you are taking:

_____
_____
_____

Are you allergic to any drugs or substances:
Penicillin Aspirin Codeine Acrylic Metals Latex NONE
Others: _____

Do you or have used Tobacco? ____ Presently ___Past if so , what type?_____

Women are you:
____ Pregnant or trying to get pregnant ____ Nursing ____ Taking oral contraceptives

Do you or have you ever had: (please circle yes or no)

A heart murmur	yes/no	Diabetes	yes/no	kidney disease	yes/no
Rheumatic Fever	yes/no	Chemo	yes/no	Thyroid disease	yes/no
Endocarditis	yes/no	Radiation	yes/no	liver disease	yes/no
Angina/Chest pain	yes/no	Lung disease	yes/no	Blood disease	yes/no
Mitral valve prolapse	yes/no	hepatitis	yes/no	Cancer	yes/no
Any heart disease	yes/no	tuberculosis	yes/no	Excessive bleeding	yes/no
Heart surgery	yes/no	Asthma	yes/no	Epilepsy	yes/no
A pace maker	yes/no	High Blood pressure	yes/no	**Joint Replacement**	yes/no

Have you ever been hospitalized or had surgery for any reason?_____
If so, please explain:_____

Is there anything else you would like our doctor to know? _____

Patient signature: _____ Date _____

Bush & Howard Dental Office

Patient Name_____

General Consent to Exam And Treatment

I hereby authorize Dr. Paul Howard, Dr. Bush, and their associates and staff located at 109 Johnson Avenue, Schoharie, NY to perform upon me or the named patient the necessary diagnostic test and treatments to determine the condition of my oral health. This shall include all physical examinations, dental radiographs, and any other diagnostic tests determined to be necessary for a complete examination by the overseeing dentist and staff. I consent to treatment including a dental examination, radiographs, and prophylaxis (cleaning), as may be ordered by the dentist to best determine my current state of oral health. I understand that as a result of this examination, I will be advised by the dentist and staff as to any course of treatment and possible alternative treatment necessary to restore my optimum oral health. I understand that during the course of the procedures, unforeseen conditions may arise which require further treatment from those contemplated, and I have been given no guarantees or assurances by anyone as to the results obtained.

I understand that I am responsible for all fees regardless of insurance coverage and I agree to submit all payments in a timely manner.

I confirm that I Have read, agree to, and fully understand the above consent.

X_____

Signature of Patient (or parent/guardian if a minor) Date

Acknowledgement of Receipt of Notice of Privacy Practices
And
Consent to Use & Disclosure of Personal Health Information

By signing below, I hereby acknowledge that I have been offered a copy of this Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by this office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations of this office.

X_____

Signature of patient (or parent/guardian if a minor) Date