E R N E S T   S.   O R P H A N O S,   D. D. S. P. A.
Diplomate of the American Board of Periodontology

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Patient ______________________________ Date ______________

Address ______________________________

City ______________________________ State ______ Zip ______

Sex: ☐ M ☐ F Age_____ Birthdate __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# ______________________ Occupation ______________________

Employer ______________________________

Employer Address ______________________ Employer Phone ______________________

Spouse's Name ______________________ Birthdate ______________________

SS# ______________________ Occupation ______________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________ Relationship to Patient ______________

Insurance Co ______________________ Group # ______________________

Is patient covered by additional insurance? o Yes o No Subscriber's Name ______________________

Birthdate ______________________ SS# ______________________

Relationship to Patient ______________________ Insurance Co. ______________________

Group # ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________

and assign directly to Dr. ______________________ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________ Relationship ______________ Date ______________

3 PHONE NUMBERS

Home ______________ CELL ______________ EMAIL ______________________

Best time and place to reach you ______________________________

INCASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone ______________________ Work Phone ______________________

Reorder 4/11 OBS 1-800-634-1876

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Periodontics
& Implantology

Dental Registration and History

Name:________________________________ Date of Birth:__________

How would you like to be addressed: ____________________________

Whom may we thank for this referral? ____________________________

Are you taking any OR have you taken any of the following medication?

Dosage? **For How Many Years?**

Fosamax:

Actonel:

Boniva

Aredia:

Zometa:

Reclast:

Doctor's notes____

Are you taking OR have you taken any of the following medications (blood thinners)?

Dosage? **For How Many Years?**

Vitamin E:

Aspirin:

Plavix: (clopidogrel)

Coumadin (warfarin):

Persantine (dipyridamole):

Lovenox (enoxaparin):

Doctor's notes: ____

Are you allergic to any of the following?

Latex gloves:	Yes	No
Penicillin:	Yes	No
Codeine:	Yes	No
Aspirin:	Yes	No

List All Other Allergies:

____

Doctor's notes: ____

List All medications (include Non-Prescription) that you are currently taking:

Medication: Dosage: For what condition?

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____

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ERNEST S. ORPHANOS, D.D.S. P.A.

Diplomate of the American Board of Periodontology

Periodontics & Implantology

Please Check All of the Following Questions that Apply to You
Do you or did you have any of the following?

Replaced Heart Valves	☐	Blood Transfusion	☐	Liver Disease	☐
Previous Bacterial Endocarditis	☐	Emphysema	☐	Hepatitis	☐
Mitral Valve Prolapse	☐	Tuberculosis	☐	Arthritis	☐
Heart Pace Make	☐	Asthma	☐	Pain in Jaw Joints	☐
Rheumatic Fever	☐	Sinus Trouble	☐	Herpes	☐
Prosthetic Joints (knee, hip replacements, pins in any bones etc.)	☐	Cancer	☐	HIV Positive	☐
		Radiation Therapy	☐	Psychiatric Care	☐
Heart Surgery	☐	Chemotherapy	☐	Fainting/ Dizziness	☐
Angina Chest Pain	☐	Kidney Problems	☐	Vertigo	☐
Heart Attack	☐	Dialysis	☐	History of Alcohol Abuse	☐
Heart Murmur	☐	Ulcers	☐	History of Drug Abuse	☐
Blood Pressure: High/ Low	☐	Intestinal Disease	☐	Do you smoke	☐
Stroke	☐	Thyroid Disease	☐	Did you ever smoke	☐
Anemia	☐	Diabetes: Type I or II	☐		
Excessive Bleeding	☐	Hypoglycemia	☐	**Females**:	
				Are you pregnant	☐
				Trying to get pregnant	☐
				Nursing?	☐
				Taking birth control?	☐

Have you ever been hospitalized or had a major operation in the past 5 years? Discuss__________________
Have you ever had a serious injury to the head/ neck? Discuss__________________
Have you ever had any other illness not listed above? Discuss__________________

Date of last physical examination by your physician: __________________
Physician's Name: __________________ Number:__________________
Pharmacy's Name: __________________ Number:__________________

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist at the next appointment without fail.

Patient Signature: ______________________________ Date:__________________

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P e r i o d o n t i c s
& I m p l a n t o l o g y

Acknowledgment Notice of Privacy Practice
Ernest S. Orphanos, D.D.S., P.A.

I,_______________________________, am aware that the office of Ernest S. Orphanos, D.D.S., P.A. does comply with HIPPA and Florida Law Privacy Regulations.

The office has the policies posted in the reception area, which I have read and I am aware that any revisions will be effective as soon as they are posted in the reception area.

I am aware that at any time I may request a copy of my records and an accounting of their disclosure.

If I have any questions I will direct them to one of the office staff.

Signature of Patient:____

(Date)

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