

PATIENT REGISTRATION

ID: _____ Chart ID: _____ Last Name: _____ Middle Initial: _____
 First Name: _____ Preferred Name: _____

Patient Is: Policy Holder
 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: _____ Drivers Lic: _____

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: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

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

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____
 Previous Dentist: _____
 Emergency Contact: _____
 Emergency Contact #: _____
 Physician: _____
 Physicians #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: 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: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: 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: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Medical History Form

Patient Name: _____ Emergency Contact _____

Date of Birth: _____ Emergency Contact Phone _____

Sex: _____ Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis Yes No

Persistent cough greater than a 3 week duration Yes No

Cough that produces blood Yes No

Been exposed to anyone with tuberculosis Yes No

Medical History

Are you now under the care of a physician? Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

Do you wear contact lenses? Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

- Pregnant Yes No
- Number of weeks _____
- Taking birth control pills or hormonal replacement? Yes No
- Nursing? Yes No

Allergies, Are you allergic to or have you had any reaction to

- | | | | | | | | |
|--|-------|---------------------------|--------------------------|------------------------------------|-------|---------------------------|--------------------------|
| Local anesthetics | | <input type="radio"/> Yes | <input type="radio"/> No | Latex (rubber) | | <input type="radio"/> Yes | <input type="radio"/> No |
| Aspirin | | <input type="radio"/> Yes | <input type="radio"/> No | Iodine | | <input type="radio"/> Yes | <input type="radio"/> No |
| Penicillin or other antibiotics | | <input type="radio"/> Yes | <input type="radio"/> No | Hay fever/seasonal | | <input type="radio"/> Yes | <input type="radio"/> No |
| Barbiturates, sedatives, or sleeping pills | | <input type="radio"/> Yes | <input type="radio"/> No | Animals | | <input type="radio"/> Yes | <input type="radio"/> No |
| Sulfa drugs | | <input type="radio"/> Yes | <input type="radio"/> No | Food | | <input type="radio"/> Yes | <input type="radio"/> No |
| Codeine or other narcotics | | <input type="radio"/> Yes | <input type="radio"/> No | Other | | <input type="radio"/> Yes | <input type="radio"/> No |
| Metals | | <input type="radio"/> Yes | <input type="radio"/> No | If Other, please specify:
_____ | | | |

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

- | | | | | | | | |
|--------------------------------------|-------|---------------------------|--------------------------|--|-------|---------------------------|--------------------------|
| Artificial (prosthetic) heart valve | | <input type="radio"/> Yes | <input type="radio"/> No | Unrepaired, cyanotic CHD | | <input type="radio"/> Yes | <input type="radio"/> No |
| Previous infective endocarditis | | <input type="radio"/> Yes | <input type="radio"/> No | Repaired (completely) in the last 6 months | | <input type="radio"/> Yes | <input type="radio"/> No |
| Damaged valves in transplanted heart | | <input type="radio"/> Yes | <input type="radio"/> No | Repaired CHD with residual defects | | <input type="radio"/> Yes | <input type="radio"/> No |
| Congenital heart disease (CHD) | | <input type="radio"/> Yes | <input type="radio"/> No | | | | |

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

- | | | | | | | | |
|--------------------------------|-------|---------------------------|--------------------------|---|-------|---------------------------|--------------------------|
| Cardiovascular disease | | <input type="radio"/> Yes | <input type="radio"/> No | Blood transfusion | | <input type="radio"/> Yes | <input type="radio"/> No |
| Angina | | <input type="radio"/> Yes | <input type="radio"/> No | If yes, date _____ | | | |
| Arteriosclerosis | | <input type="radio"/> Yes | <input type="radio"/> No | Hemophilia | | <input type="radio"/> Yes | <input type="radio"/> No |
| Congestive heart failure | | <input type="radio"/> Yes | <input type="radio"/> No | AIDS or HIV | | <input type="radio"/> Yes | <input type="radio"/> No |
| Damaged heart valves | | <input type="radio"/> Yes | <input type="radio"/> No | Arthritis | | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart attack | | <input type="radio"/> Yes | <input type="radio"/> No | Autoimmune disease | | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart murmur | | <input type="radio"/> Yes | <input type="radio"/> No | Rheumatoid arthritis | | <input type="radio"/> Yes | <input type="radio"/> No |
| Low blood pressure | | <input type="radio"/> Yes | <input type="radio"/> No | Systemic lupus erythematosus | | <input type="radio"/> Yes | <input type="radio"/> No |
| High blood pressure | | <input type="radio"/> Yes | <input type="radio"/> No | Asthma | | <input type="radio"/> Yes | <input type="radio"/> No |
| Other congenital heart defects | | <input type="radio"/> Yes | <input type="radio"/> No | Bronchitis | | <input type="radio"/> Yes | <input type="radio"/> No |
| Mitral valve prolapse | | <input type="radio"/> Yes | <input type="radio"/> No | Emphysema | | <input type="radio"/> Yes | <input type="radio"/> No |
| Pacemaker | | <input type="radio"/> Yes | <input type="radio"/> No | Sinus trouble | | <input type="radio"/> Yes | <input type="radio"/> No |
| Rheumatic fever | | <input type="radio"/> Yes | <input type="radio"/> No | Tuberculosis | | <input type="radio"/> Yes | <input type="radio"/> No |
| Rheumatic heart disease | | <input type="radio"/> Yes | <input type="radio"/> No | Cancer/Chemotherapy/Radiation Treatment | | <input type="radio"/> Yes | <input type="radio"/> No |
| Abnormal bleeding | | <input type="radio"/> Yes | <input type="radio"/> No | Chest pain upon exertion | | <input type="radio"/> Yes | <input type="radio"/> No |
| Anemia | | <input type="radio"/> Yes | <input type="radio"/> No | Chronic pain | | <input type="radio"/> Yes | <input type="radio"/> No |

Diabetes Type I or II Yes No

Eating disorder Yes No

Malnutrition Yes No

Gastrointestinal disease Yes No

G.E. Reflux/persistent heartburn Yes No

Thyroid problems Yes No

Stroke Yes No

Glaucoma Yes No

Hepatitis, jaundice or liver disease Yes No

Epilepsy Yes No

Fainting spells or seizures Yes No

Neurological disorders Yes No

If yes, please specify _____

Sleep disorder Yes No

Mental health disorders Yes No

Specify _____

Recurrent infections Yes No

Type of infection _____

Kidney problems Yes No

Night sweats Yes No

Osteoporosis Yes No

Persistent swollen glands in neck Yes No

Severe headaches/migraines Yes No

Severe or rapid weight loss Yes No

Sexually transmitted disease Yes No

Excessive urination Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Please explain _____

Signature of Patient/Legal Guardian

Insurance Authorization - Signature On File

BRIAN GLESNE, D.M.D.
GLESNE FAMILY DENTISTRY
3307 GRIFFIN AVENUE
PEKIN, ILLINOIS 61554
PHONE: 309-347-3066

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

This authorization shall remain in effect indefinitely unless and until I revoke it in writing. Any revocation will apply only to future services and will not affect charges or claims already submitted or services already rendered. I understand that this authorization does not expire annually and remains valid for all current and future services unless revoked in writing.

Today's Date

Signature of Patient or Insured

Witnessed By

DR. BRIAN L. GLESNE

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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DR. BRIAN L. GLESNE

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **FRONT DESK** _____

Telephone: **347-3066** _____ Fax: **347-2853** _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____