

**PATIENT REGISTRATION**

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder

Preferred Name: \_\_\_\_\_

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  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

Section 3

Employment Status:  Full Time  Part Time  Retired

PATIENT DID NOT PAY: \_\_\_\_\_

Student Status:  Full Time  Part Time

CARRINGTON: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ 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: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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

**MEDICAL HISTORY**

FOR

1836--BLOCK BLOCK

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 \_\_\_\_\_
- 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     Acrylic     Metal     Latex     Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_

# **Patient Acknowledgement Form**

## **Receipt of Dental Materials Fact Sheet**

I have read and understand The Dental Board of California's Dental Materials Fact Sheet, or my dentist has given me a copy.

My dentist has explained the reasons for recommending a specific type of dental restoration material.

If I am pregnant, a diabetic, or a parent/ guardian of a child patient, I have discussed the pros and cons of amalgam restoration with my dentist.

If I had unusually sensitive reactions to other materials in the past, I have discussed this sensitivity with my dentist prior to restoration work.

I have had the chance to ask any questions I may have, and have received satisfactory answers to those questions

Additional comments: \_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Creekside Dentsitry  
Hamid Nasr DDS  
1625 Creekside Dr Ste100  
Folsom CA 95630**

CREEKSIDE DENTISTRY  
HAMID NASR, DDS  
1625 CREEKSIDE DR STE100  
FOLSOM CA 95630

## **HIPAA/ NOTICE OF PRIVACY PRACTICES**

I HAVE READ AND UNDERSTAND THE COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I WOULD LIKE TO HAVE A COPY THE OFFICE IS REQUIRED TO GIVE ME ONE.

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PRINT NAME

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

---

DATE

# PATIENT INFORMED CONSENT

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## Creekside Dentistry

Dr. Hamid Nasr D. D. S.  
1625 Creekside Dr. Ste 100  
Folsom, CA 95630  
Ph: (916) 983-8777  
F: (916) 983-2096

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Examinations and X-Rays**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

Initials \_\_\_\_\_

2. **Drugs, Medications, and Sedation**

I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which may be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetics, medications, and/ or drugs that may have been given to me in this office for my care. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Initials \_\_\_\_\_

3. **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes if necessary.

Initials \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Watermark Medical ARES Questionnaire

**PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX**

First Name		Middle Initial		Last Name		Tally ARES Risk Points
<b>Weight</b>	Pounds		<b>Age</b>	Years		Gender Male <input type="radio"/> Female <input type="radio"/>
	Feet			Inches		
<b>Height</b>	Feet		Inches		<b>Neck Size</b>	Inches
	Month		Day			
<b>Date of Birth</b>		Month		Day		<b>ID Number</b>
		Year		Optional		

**COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS**

<b>Have you been diagnosed or treated for any of the following conditions?</b>						Co-morbidities +1 for each Yes response
High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>	Score
Heart disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>	
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep apnea	Yes <input type="radio"/>	No <input type="radio"/>	
Lung disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal oxygen use	Yes <input type="radio"/>	No <input type="radio"/>	Do not assign any points for these eight responses
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless leg syndrome	Yes <input type="radio"/>	No <input type="radio"/>	
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>	
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., vicodin, oxycontin	Yes <input type="radio"/>	No <input type="radio"/>	

<p><b>Epworth Sleepiness Scale:</b> How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)</p> <p><b>0 = would never doze</b>                      <b>1 = slight chance of dozing</b></p> <p><b>2 = moderate chance of dozing</b>      <b>3 = high chance of dozing</b></p>								Epworth Score <b>TOTAL</b> the values from all 8 questions, If 11 or less <b>Score = 0</b> If 12 or more <b>Score = 2</b>
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>				
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

<b>Frequency</b>	<b>0 - 1 times/week</b>	<b>1 - 2 times/week</b>	<b>3 - 4 times/week</b>	<b>5 - 7 times/week</b>		
<b>On average in the past month, how often have you snored or been told that you snored?</b>						
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4		
<b>Do you wake up choking or gasping?</b>						
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4		
<b>Have you been told that you stop breathing in your sleep or wake up choking or gasping?</b>						
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4		
<b>Do you have problems keeping your legs still at night or need to move them to feel comfortable?</b>						
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>		

Signature	Area Code	Phone Number	<b>Total all 6 boxes from above</b>	<b>Point Total</b>
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	