PATIENT REGISTRATION AND HEALTH HISTORY

DATE_____

Patient Name _____How do you prefer to be addressed?_____

Mailing Address_____ City_____ State_____ Zip _____

Home Phone Number _____ Sex: M F Age ____ Birth date: _____ SS# _____

Cell Phone Number _____ Work Phone Number _____

Email address_____ Would you like to receive email ____ or text reminders ____ Cell Carrier _____

Employer _____

Name of responsible party _____ Relationship to Patient_____

INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS# _____DOB _____

Name of Employer_____ Employer Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Answers to the following questions are for our records only and will be considered confidential.

Date of last physical examination _____ Physician's Name _____

Date of last dental examination _____Date of last dental x-rays _____ Previous Dentist's name _____

WOMEN: Are you pregnant now? Yes No If yes, when is your due date? _____
Are you currently breast feeding? Yes No Are you taking oral contraceptives? Yes No

Do you have any drug allergies or have you had an adverse reaction to any medication?

Aspirin __ Barbiturates __ Codeine __ Iodine __ Latex __ Penicillin __ Sulfa __ Metals __ Other _____

Please list medications you are currently taking. _____

Pharmacy _____ Phone # _____

Place a mark on yes or no to indicate if you have had any of the following:

Chest Pain	Yes	No	Shortness of Breath	Yes	No	Hives or skin rash	Yes	No
Ulcers	Yes	No	Alcoholism	Yes	No	Intellectual Disability	Yes	No
Herpes	Yes	No	Angina Pectoris	Yes	No	Emphysema	Yes	No
Glaucoma	Yes	No	Heart Problems	Yes	No	*Steroid Treatment	Yes	No
Cancer (type:)	Yes	No	Chemotherapy	Yes	No	Hemophilia	Yes	No
Liver Disease	Yes	No	Fainting or dizzy spells	Yes	No	Radiation Therapy	Yes	No
Eating Disorder	Yes	No	Arthritis	Yes	No	Cold Sores	Yes	No
Diabetes	Yes	No	Epilepsy or seizures	Yes	No	*Any type implant	Yes	No
Persistent Cough	Yes	No	High Blood Pressure	Yes	No	Dentures/Partials	Yes	No
*Heart Murmur	Yes	No	Tuberculosis (TB)	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	HIV Positive, ARC, Aids	Yes	No	Asthma	Yes	No
Hay fever	Yes	No	*Congenital Heart Problems	Yes	No	Heart Pacemaker	Yes	No
Sickle Cell Disease	Yes	No	Psychiatric treatment	Yes	No	Bruise Easily	Yes	No
Stroke	Yes	No	Hepatitis	Yes	No	Jaundice	Yes	No
Sinus Trouble	Yes	No	Kidney Trouble	Yes	No	Drug addiction	Yes	No
*Artificial Joints	Yes	No	Thyroid Disease	Yes	No	Blood Transfusion	Yes	No
Anemia	Yes	No	Use of tobacco products	Yes	No	*Any type of transplant	Yes	No
			*Mitral Valve Prolapse	Yes	No	High Cholesterol	Yes	No

***Antibiotic pre-medication may be required prior to your appointment.**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Guardian _____

Revised 2013

LISKA & HOVLAND, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

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: Dr. Greg Liska, DDS
Telephone: (763)546-2209 Fax: (763)546-9107
Address: 1025 Evergreen Ln. N., Plymouth MN 55441

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: _____