JOHN J. LENZ, D.D.S.
ANTHONY W. VATTLIANA, D.D.S.
MICHAEL D. LENZ, D.M.D.
2309 PENNSYLVANIA AVENUE
WILMINGTON, DELAWARE 19806

CONFIDENTIAL PATIENT REGISTRATION

Date ____________________

Patient's Name ____

Date of Birth ____________ Patient's Social Security Number ______________________ M F

Name of Spouse ____

If a Child, Parent's Name ____

Street Address ____ Phone ( ) ____________

Cell ( ) ____________

City ____________________ State ________ Zip ____________ Email ______________

Whom may we thank for referring you? ______________________________________

Please list any dental concerns you may have ____________________________________

Full-Time Student ____________________ Name of School ______________________

Patient Employed by ________________________ Occupation ______________________

Business Address ______________________________________ Phone ( ) ____________

Spouse Employed by ________________________ Occupation ______________________

Business Address ______________________________________ Phone ( ) ____________

In case of emergency, who should be notified? ____________________ Phone ( ) ____________

Name of Contact Person (neighbor or relative) ____________________ Phone ( ) ____________

Person responsible for this account ____

Name and address of primary dental insurance company ______________________________

Name of insured ______________________________________ Date of Birth ____________

Insured's Social Security Number ____

Name and address of secondary dental insurance company ____________________________

Name of insured ______________________________________ Date of Birth ____________

Insured's Social Security Number ____

(OVER)

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TELEPHONE (302) 654-6915
FACSIMILE (302) 654-3218

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.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT **DATE**

Name____

Address:______________________________________

Telephone:____________________Email:____________________

Social Security Number__________________________________

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.
If applicable, I authorize this office to leave a message reminding to take my pre-medication when the confirmation call is placed.
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.

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:

PersonalRepresentative'sName________________________________

Relationship to Patient:__________________________________

HEALTH HISTORY
(Please answer each question)

1. Name of family physician ______________________________

2. Are you under the care of a specialist other than your primary care physician? Yes ___ No ___
   Specialist's Name ______________________________
   Condition being treated ______________________________

3a. Have you been hospitalized within the last 5 years? Yes ___ No ___
   If yes, explain ______________________________
 b. Have you been treated in a rehabilitation center? Yes ___ No ___
   If yes, explain ______________________________

4. (Women) Are you Pregnant? Due Date ____________ No____

5. Do you use tobacco in any form? Yes ___ No ___
   If yes, how much & what form ______________________________

6. Do you have or have you had any of the following:

Sinus Problems	Yes ___	No ___	Infective Endocarditis	Yes ___	No ___
Stroke	Yes ___	No ___	Shunt	Yes ___	No ___
Convulsion/Epilepsy	Yes ___	No ___	Heart Attack/Trouble	Yes ___	No ___
Tuberculosis	Yes ___	No ___	High Blood Pressure	Yes ___	No ___
Asthma/Hay Fever	Yes ___	No ___	Congenital Heart Disease	Yes ___	No ___
Diabetes	Yes ___	No ___	Heart Valve/Joint Replacement	Yes ___	No ___
Hepatitis	Yes ___	No ___	Pacemaker	Yes ___	No ___
Ulcers	Yes ___	No ___	Heart Surgery	Date ____________	No ___
Cancer/Tumors	Yes ___	No ___	Abnormal Bleeding	Yes ___	No ___
Anemia	Yes ___	No ___	Other-explain ______________________		
Positive HIV Test	Yes ___	No ___	______________________		

7. Are you allergic or have ever experienced a reaction to the following:

Local Anesthetics	Yes ___	No ___	Aspirin or Codeine	Yes ___	No ___
Penicillin/Other Antibiotics	Yes ___	No ___	Other-explain ______________________		
Sulfa Drugs	Yes ___	No ___	______________________		

8. Are you taking any of the following:

Antibiotics/Sulfa Drugs	Yes ___	No ___	Blood Thinners	Yes ___	No ___
Tranquilizers	Yes ___	No ___	Blood Pressure Medicine	Yes ___	No ___
Insulin/Diabetic Drugs	Yes ___	No ___	Recreational Drugs	Yes ___	No ___
Thyroid Medicine	Yes ___	No ___	Heart Medication	Yes ___	No ___
Cortisone/Steroids	Yes ___	No ___	Nitroglycerin	Yes ___	No ___
Allergy Drugs/Cold Remedies	Yes ___	No ___	Aspirin/Ibuprofen	Yes ___	No ___
Dilantin/Epileptic Drugs	Yes ___	No ___	Other-explain ______________________		
Bisphosphonate (Osteoporosis/Cancer)	Yes ___	No ___	______________________		

9. Is there any other disease, condition, or problem not listed above of which you think we should be aware?

____

____

I understand that dental insurance may not cover all portions of the treatment rendered and that I am responsible for any balance on my account.

Signature ______________________________ Date ____________