NEW PATIENT REGISTRATION FORM

Perseus Dental - DFW Mobile Dentistry

PATIENT INFORMATION

Full Name: ____
Preferred Name: ____
Date of Birth: ____ / ____ / ______
Age: _______ **Gender:** □ Male □ Female □ Other □ Prefer not to say

Primary Address: ____
City: __________________ State: ______ Zip: __________

Facility Name (if applicable): ____________________________
Room #: __________

Primary Phone: __________________________

Email Address: ____

RESPONSIBLE PARTY / LEGAL GUARDIAN (if applicable)

Name: ____
Relationship to Patient: ____________________________

Phone: __________________________
Email: __________________________

Address (if different): ______________________________

Legal Authority: □ Power of Attorney □ Legal Guardian □ Caregiver □ Other: __________

EMERGENCY CONTACT

Name: ____
Relationship: ____________________________

Phone: __________________________

MEDICAL INFORMATION

Primary Physician: ______________________________
Physician Phone: ______________________________

Do you have any of the following conditions? (check all that apply)
☐ Alzheimer’s / Dementia
☐ Parkinson’s Disease
☐ Stroke
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Respiratory Conditions
☐ Seizure Disorder
☐ Cancer
☐ Other: ____

Allergies: ____

Current Medications (or attach list):

Mobility Status:
☐ Independent ☐ Walker ☐ Wheelchair ☐ Bedbound

Special Needs / Behavioral Considerations:

DENTAL INFORMATION

Reason for Today’s Visit: ________________________________

Last Dental Visit: ____ / ____ / ______

Do you have any of the following?
☐ Tooth Pain ☐ Broken Teeth ☐ Dentures ☐ Difficulty Chewing ☐ Bleeding Gums

Oral Hygiene Assistance Needed: ☐ Yes ☐ No

CONSENT & AUTHORIZATION

I authorize Perseus Dental to provide dental care for the patient listed above. I understand that treatment will be performed in our wheelchair-accessible mobile treatment unit.

I authorize release of medical and dental information necessary for treatment and insurance processing.

Signature (Patient/Guardian): ____________________________
Printed Name: ____________________________

Date: ____ / ____ / ______

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Signature: ____________________________
Date: ____ / ____ / ______