Edward S. Lazer, D.D.S
COSMETIC & ADVANCED
DENTISTRY
5 Park Center, Suite 302, Owings Mills, Maryland 21117

REGISTRATION HISTORY

DATE_____

PATIENTS NAME_____DATE OF BIRTH_____

IF A CHILD, RESPONSIBLE PARTY'S NAME _____S.S#_____

STREET ADDRESS_____PHONE_____

CITY_____STATE_____ZIP_____CELL PHONE_____

PATIENT EMPLOYED BY_____BUSINESS PHONE_____

PURPOSE OF THIS APPOINTMENT_____EMAIL_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____PHONE_____

WHO WILL PAY THIS ACCOUNT_____

NAME OF DENTAL INS. COMPANY_____SUBSCRIBER & S.S#_____

WHOM MAY WE THANK FOR REFERRING YOU (RADIO, SUNPAPER, BALTO. MAG, DENTAL LIFE, OTHER)_____

SINGLE_____MARRIED_____DIVORCED_____WIDOWED_____SEPARATED_____

NAME OF SPOUSE_____

SPOUSE EMPLOYED BY_____PHONE_____SPOUSE'S S.S.#_____

APPLICANT'S SIGNATURE_____

MEDICAL HISTORY

DATE OF LAST HEALTHCARE EXAM_____FOR WHAT_____LAST DENTAL EXAM_____

HAVE YOU BEEN HOSPITALIZED IN THE PAST 5 YEARS_____IS SO, FOR WHAT_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N ABNORMAL BLEEDING	Y N FREQUENT HEADACHES	Y N MITRAL VALVE PROLAPSE
Y N ALCOHOL / DRUG ABUSE	Y N GLAUCOMA	Y N PACEMAKER
Y N ANEMIA	Y N HAY FEVER	Y N PSYCHIATRIC PROBLEMS
Y N ARTHRITIS	Y N HEART ATTACK	Y N RADIATION TREATMENT
Y N ARTIFICIAL BONES / JOINTS / VALVES	Y N HEART MURMUR	Y N RHEUMATIC / SCARLET FEVER
Y N ASTHMA	Y N HEART SURGERY	Y N SEIZURES
Y N BLOOD TRANSFUSION	Y N HEMOPHILIA	Y N SHINGLES
Y N CANCER / CHEMOTHERAPY	Y N HEPATITIS	Y N SICKLE CELL DISEASE / TRAITS
Y N COLITIS	Y N HERPES / FEVER BLISTERS	Y N SINUS PROBLEMS
Y N CONGENITAL HEART DEFECT	Y N HIGH BLOOD PRESSURE	Y N STROKE
Y N DIABETES	Y N HIV+ / AIDS	Y N THYROID PROBLEMS
Y N DIFFICULTY BREATHING	Y N HOSPITALIZED FOR ANY REASON	Y N TUBERCULOSIS (TB)
Y N EMPHYSEMA	Y N KIDNEY PROBLEMS	Y N ULCERS
Y N EPILEPSY	Y N LIVER DISEASE	Y N VENEREAL DISEASE
Y N FAINTING SPELLS	Y N LOW BLOOD PRESSURE	Y N SMOKING

HAVE YOU OR ANY OF YOUR SEXUAL PARTNERS TESTED POSITIVE FOR HIV OR AIDS?_____

DO YOU FEEL YOU ARE AT RISK FOR HIV / AIDS?_____ NAME OF YOUR PHYSICIAN_____

LIST ANY CURRENT MEDICATIONS_____

IF SO, FOR WHAT?_____

OTHER PHYSICAL CONDITIONS (NOT LISTED ABOVE)_____

DATE_____SIGNATURE_____

COSMETIC & ADVANCED

DENTISTRY

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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Cosmetic & Advanced Dentistry (Dr. Edward Lazer, Dr. Roham Rafat, Dr. Pratik Patel) notice of Privacy Practices. By signing below I am only giving acknowledgment that I have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature