**LARRY E. TRAGESSER, D.D.S.**
9000 KINGSTON PIKE
KNOXVILLE, TN 37923
865-693-1047

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| PATIENT'S LAST NAME | FIRST NAME | M.I. | DATE OF BIRTH | PRIMARY PHYSICIAN'S NAME |
|---|---|---|---|---|
| | | | | |

| MAIDEN NAME | NAME YOU GO BY | MARITAL STATUS ☐ S ☐ M ☐ D ☐ W |
|---|---|---|
| | | |

| STREET ADDRESS | APT. NO. |
|---|---|
| | |

| CITY | STATE | ZIP | HOME PHONE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY NO. | AGE | GENDER ☐ Male ☐ Female | CELL PHONE |
|---|---|---|---|
| | | | |

| EMPLOYER | OCCUPATION | WORK PHONE |
|---|---|---|
| | | |

| EMERGENCY CONTACT (NOT LIVING WITH YOU)/RELATION TO PATIENT | EMERGENCY CONTACT PHONE |
|---|---|
| | |

## SPOUSE OR PARENT/RESPONSIBLE PARTY INFORMATION

| LAST NAME | FIRST NAME | M.I. | RELATIONSHIP TO PATIENT ☐ Parent ☐ Legal Guardian ☐ Other ________ |
|---|---|---|---|
| | | | |

| STREET ADDRESS | APT NO. | HOME PHONE |
|---|---|---|
| | | |

| CITY | STATE | ZIP | CELL PHONE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY NO. | DATE OF BIRTH |
|---|---|
| | |

| RESPONSIBLE PARTY EMPLOYER | OCCUPATION | RESPONSIBLE PARTY WORK PHONE/EXT. |
|---|---|---|
| | | |

## SECOND PARENT INFORMATION

| LAST NAME | FIRST NAME | M.I. | RELATIONSHIP TO PATIENT ☐ Parent ☐ Legal Guardian ☐ Other ________ |
|---|---|---|---|
| | | | |

| STREET ADDRESS | APT NO. | HOME PHONE |
|---|---|---|
| | | |

| CITY | STATE | ZIP | CELL PHONE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY NO. | DATE OF BIRTH |
|---|---|
| | |

| RESPONSIBLE PARTY EMPLOYER | OCCUPATION | RESPONSIBLE PARTY WORK PHONE/EXT. |
|---|---|---|
| | | |

## INSURANCE INFORMATION

| PRIMARY INURANCE COMPANY | COPAY | EFFECTIVE DATE |
|---|---|---|
| | | |

| ID (POLICY NO.) | GROUP NO. |
|---|---|
| | |

| SUBSCRIBER | RELATIONSHIP TO SUBSCRIBER | SUBCRIBER'S DATE OF BIRTH |
|---|---|---|
| | | |

| SUBSCRIBER'S EMPLOYER | SUBSCRIBER'S SOCIAL SECURITY NO. |
|---|---|
| | |

| SECONDARY INURANCE COMPANY | COPAY | EFFECTIVE DATE |
|---|---|---|
| | | |

| ID (POLICY NO.) | GROUP NO. |
|---|---|
| | |

| SUBSCRIBER | RELATIONSHIP TO SUBSCRIBER | SUBCRIBER'S DATE OF BIRTH |
|---|---|---|
| | | |

| SUBSCRIBER'S EMPLOYER | SUBSCRIBER'S SOCIAL SECURITY NO. |
|---|---|
| | |

***HOW DID YOU HEAR ABOUT US?***

☐ Friend or relative ____________________ ☐ Insurance provider list

☐ Referred by another physician/Dr. ____________________ ☐ Other ____________________

**Insurance Payment Authorization and Release:** I hereby authorize my insurance benefits to be paid directly to Larry Tragesser, DDS and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release or any information requested by my insuarance company.

Authorized signature ______________________________ Date ____________________

***WELCOME*** **Patient's Name** ______________________

1. **Primary Care Physician's Name:** ____________________ **Phone:** ______________
2. When was your last physical exam? ____________________

| | | Y | N |
|---|---|---|---|
| 3. | Are you taking any medications? (please list on backside) | Y | N |
| 4. | Do you routinely take health related substances? | Y | N |
| 5. | Are you allergic to any medications? (please list on backside) | Y | N |
| 6. | Are you sensitive to any metals or latex? | Y | N |
| 7. | Are you pregnant or suspect you may be? | Y | N |
| 8. | Do you use any birth control medications? | Y | N |
| 9. | Have you ever been treated for heart disease? | Y | N |
| 10. | Do you have a pacemaker, an artificial heart valve implant or been diagnosed with mitral valve prolapsed? | Y | N |
| 11. | Have you ever had rheumatic fever? | Y | N |
| 12. | Do you have high or low blood pressure? | Y | N |
| 13. | Have you ever had a serious illness or major surgery? | Y | N |
| 14. | Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? | Y | N |
| 15. | Have you ever taken Fosamax, Zometa, Aredia or (bisphosphonates) for bone tumors, excessive calcium in your blood? | Y | N |
| 16. | Do you have inflammatory diseases, such as arthritis or rheumatism? | Y | N |
| 17. | Do you have any artificial joints/prosthesis? | Y | N |
| 18. | Do you have any blood disorders (anemia, leukemia)? | Y | N |
| 19. | Do you have any stomach problems? | Y | N |
| 20. | Do you have any kidney problems? | Y | N |
| 21. | Do you have any liver problems? | Y | N |
| 22. | Are you diabetic?. | Y | N |
| 23. | Do you have asthma? | Y | N |
| 24. | Do you have epilepsy or seizure disorders? | Y | N |
| 25. | Have you tested HIV positive? | Y | N |
| 26. | Do you have AIDS? | Y | N |
| 27. | Have you had or do you test positive for hepatitis? | Y | N |
| 28. | Do you or have you had T.B.? | Y | N |
| 29. | Do you smoke, chew or use any other form of tobacco? | Y | N |
| 30. | Do you regularly consume more than 1 or 2 alcoholic drinks per day? | Y | N |
| 31. | Have you had psychiatric treatment? | Y | N |
| 32. | Have you ever taken any prescription drugs fenfluramine, Fenfluramine combined with phentermine (fen-phen), Dexfenfluramine (redux), or weight loss products? | Y | N |
| 33. | Is there anything else we should know about your health that we Have not covered on this form? (please list on backside) | Y | N |

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:**

PATIENT'S SIGNATURE: ______________________________ Date ____________

Larry E. Tragesser D.D.S

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 can be provided.

**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 office. 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.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(please check one)

- ☐ Yes, I have received a copy of the privacy practices.
- ☐ No, I do not need a copy.

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 operations.

SIGNATURE ______________________________ DATE ________________