Welcome To Our Practice!

Please take a few minutes to answer the following questions so we may better assist you.

Patient Information Today's Date _____

Name _____ **Home Phone** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Birth date _____ **Social Security#** _____ **Drivers License#** _____

Cell Phone _____ **Email** _____

Preferred method of contact: Phone Cell or **Home**, **Text**, or **Email** Phone Cell

Sex: M ☐ **F** ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Seperated** ☐ **Divorced** ☐ **Widowed** ☐

Spouses Name _____ **If Minor: Father** _____ **Mother** _____

Employer _____ **Business Phone** _____

Business Address _____ **Occupation** _____

Who may we thank for referring you? _____

Primary Dental Insurance: please provide us with your insurance card so we may scan it, if no card please continue with next section:

Policy Holder's Name _____ **Relationship to patient** _____

Birthdate _____ **Social Security #** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Employer _____ **Business Phone** _____

Business Address _____ **Occupation** _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ **Group#** _____

Any Secondary Dental Insurance: please provide secondary insurance card so we may scan it

Insurance coverage is estimated, your actual indemnity may be less. You the patient, are responsible for all amounts not paid by your insurance carrier, should your balance not be paid in full. You the patient, are responsible for all fees incurred to collect the unpaid balance. I authorize the above doctor and/or any provider or supplier of the services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

YOU the patient, are ultimately responsible for all amounts incurred regardless of insurance coverage.

Signature of responsible party _____ **Today's Date** _____

Please continue to back of form

Dental History

What is the reason for today's visit?_____

Date of last dental visit _____ Date of last cleaning _____ Date of last xrays

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips/mouth
- ☐ Broken teeth/fillings
- ☐ Loose teeth/fillings
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity cold/hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Frequent headaches
- ☐ Teeth grinding

Medical History Physician's Name_____ Date of last visit_____

	yes	no
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had serious illness/operation?	☐	☐
3. Are currently taking medications?	☐	☐

If yes please list:_____

_____

_____

_____

	yes	no
4. Have you ever been told you are allergic to any drug?	☐	☐

If yes please list:_____

_____

5. Do you use tobacco products?	☐	☐
6. Do you regularly use drugs?	☐	☐

Please check all that apply:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artifical heart valves
- ☐ Artifical joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, after dental treatment
- ☐ Blood Disease or transfusion
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Chronic fatique syndrome
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Cough-persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Gastrointestinal condition
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems/condition
- ☐ Hepatitis Type___
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV Positive/AIDS
- ☐ Jaw pain
- ☐ Latex sensitivity
- ☐ Kidney /Bladder disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Psychiatric treatment
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Stroke/ CVA
- ☐ Swelling feet/ankles
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal disease

Women Only

Are you pregnant or think you might be pregnant? ☐ yes ☐ no If yes how many weeks/months? _____

Are you currently nursing? ☐ yes ☐ no

Do you currently take birth control pills? ☐ yes ☐ no If so what is the name:_____

Emergency Contact Informatiom: Name _____ **Phone#** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: Our office promises not to disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices document is posted and a copy is available to you at any time.

Health Insurance Portability & Accountability Act-HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

Release of Information:

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to the following:

Spouse _____
Child _____
Other _____

[ ] Information is not to be released to anyone.

SIGNATURE _____ **DATE** _____