Welcome

About You

Today's Date: ____________ E-mail Address: ____________

Name: ______________________________ I prefer to be called: ____________ ❑ Male ❑ Female

Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: ____________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ______________________________

Street City State Zip

Home Phone #: (____)________ Cell/other #: (____)________ Work Phone #: (____)________ Ext: ____ Driver's License #: ____________

Where & when are best times to reach you? ____________ Whom may we thank for referring you? ____________

Other family members seen by us: ______________________________

Employer: ____________ How long there? ____________ Occupation: ____________

Employer's Address: ______________________________

Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: ____________ Relation: ____________ Work Phone #: (____)________ Home Phone #: (____)________

Address: ______________________________

Street City State Zip

Spouse / Parent Information

His / Her Name: ____________ Birthdate: ___/___/___ Social Security #: ____________

Employer: ____________ Work Phone #: (____)________ Ext: ____ Driver's License #: ____________

Dental Insurance Information

Primary Insurance

Insurance Co. Name: ____________ Phone #: (____)________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ______________________________

Street/PO Box City State Zip

Insured's Name: ____________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/___ Relation: ____________

Insured's Employer: ____________ Employer's Address: ______________________________

Street/PO Box City State Zip

Secondary Insurance

Insurance Co. Name: ____________ Phone #: (____)________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ______________________________

Street/PO Box City State Zip

Insured's Name: ____________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/___ Relation: ____________

Insured's Employer: ____________ Employer's Address: ______________________________

Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? ____________________

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ____________________

Previous / Present Dentist: ____________________ Last Visit Date: __________
(Please Circle)

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? ____________________

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Address: ____________________
Street

____
City State Zip

Phone #: (   ) __________ Date of last visit: __________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: __________ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: ____________________

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one: ____________________

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: ____________________

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

____________________ Signature Date

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Notice of Privacy Practices Acknowledgment

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgment of having had an opportunity to receive and review a copy of our Notice of Privacy Practices.

I, ______________________________ acknowledge the opportunity to review and receive Notice of Privacy Practices.

______________________________ ______________________________
Signature Date

____
Relationship to patient if signed on behalf of the patient, legal guardian, personal representative, etc.

☐ Patient refuses, or is unable to acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________________
Employee Signature Date

Disclosures to Family and Friends and Clinical Information Calls

Under normal circumstances we would share some of your private health information (PHI) with some of your family members.

☐ I agree that this office may disclose my private health information to only the following individuals that are my family members of friends (check all that apply):

- ☐ My Spouse
- ☐ Any of my Parents
- ☐ Other (specify by name) ______________________________
- ☐ Any of my children
- ☐ Any of my Siblings

☐ I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

We will want to communicate with you regarding clinical information (such as test results and treatment plans). If we are unable to reach you at home may we:

- ☐ Call you at work
- ☐ Leave a message on the answering machine
- ☐ Other ______________________________

______________________________ ______________________________
Signature Date

____
Relationship to patient if signed on behalf of the patient, legal guardian, personal representative, etc.