Welcome

About You

Today's Date: ______ Email Address: ______

Name: ______ I prefer to be called: ______ ☐ Male ☐ Female

Last First Mi Mr Mrs Ms Dr

Birthdate: ______ Age: ______ Social Security #: ______ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Home Address: ______

Street City State Zip

Home Phone: ______ Cell / other #: ______ Work Phone #: ______ Ext: ______ Driver's License #: ______

Where & when are the best times to reach you? ______ Who may we thank for referring you? ______

Other family members seen by us: ______

Employer: ______ How long there? ______ Ocupation: ______

Employer's Address: ______

Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: ______ Relationship: ______ 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 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 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 know 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 tabacco in any form? ☐ Yes ☐ No

Have you ever taken Fosomax, 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 Milral 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 Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Hepatitis	Y N Radiation Treatment	Y N Tuberculosis (T.B.)
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 Cocaine	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 reaction: ________________

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

Notice of Privacy Practices Acknowledgement

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement 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 our 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 or friends (check all that apply):**

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

☐ **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.