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PLEASE COMPLETE BOTH SIDES OF FORM

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #:_____Birth Date:_____Email Address_____

Phone (Home): _____ (Work): _____ (Other/Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Patient's Employer/School: _____

Occupation: _____

Spouse/Parent's Name: _____Spouse/Parent's Birth Date:_____

Spouse/Parent's Social Security # _____Spouse/Parent's Employer:_____

Who is responsible for this account? _____

Relationship to Patient: _____

Does patient have dental insurance? ☐ Yes ☐ No

Name and birth date of insured/subscriber_____

Name and address of dental insurance company_____

_____Insured's ID #_____Group #_____

Is patient covered by secondary dental insurance? ☐ Yes ☐ No

Name and birth date of insured/subscriber_____

Name and address of secondary insurance_____

_____Insured's ID #_____Group #_____

Referral Information

Whom may we thank for referring you to our practice? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Name of previous dentist(s): _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
☐ Arthritis
☐ Anemia
☐ **Artificial Heart Valve** _____
☐ **Artificial Joint Replacements**_____ _____
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Diabetes
☐ Epilepsy
☐ **Excessive Bleeding**
☐ Glaucoma
☐ Liver Disease
☐ Head Injuries
☐ Heartburn-GERD
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ **High Blood Pressure**
☐ Kidney Disease
☐ Medications for bones
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Organ Transplants _____
☐ Pacemaker
☐ **Pregnant Now?**
Due Date:_____
☐ Rheumatism
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Surgeries-Past/Future _____
☐ Smoking Habit
How often?_____
☐ Tobacco Habit
How often?_____
☐ Tuberculosis
☐ Tumors
☐ Ulcers _____
☐ **Codeine Allergy**
☐ **Penicillin Allergy**
☐ **Latex Allergy**
☐ **OTHER ALLERGIES** _____ _____

Are you currently taking:
☐ Blood Thinners
☐ Heart Medications
☐ Bisphosphonates

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

• List any medications, herbal supplements, or vitamins you are now taking: _____

_____

_____

• Are you now seeing a physician, or being treated for any medical problems? ☐ Yes ☐ No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have or had any other medical problems or surgeries, such as joint replacements, heart surgery? ☐ Yes ☐ No

If yes, please explain: _____

Consent for Services

In fairness to all patients, this office charges for missed appointments without 24 hrs. prior notice.

You are responsible to know your own dental insurance and benefits.

X-rays and fluoride treatments will be done at the doctor's discretion.

I agree to be responsible for all charges. Patients who have dental insurance authorize payments to be made directly to the doctor, and the release of any information relating to claims. We will be glad to submit claims for you; however, you are ultimately responsible for the charges.

I grant my permission for the office staff to contact me by phone calls, message on answering machine, or postcards regarding appointments.

HIPAA CONSENT: I have seen and been given the opportunity to review this office's Notice of Privacy Practices. 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.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:**_____ **Relationship to patient:**_____

Signature of patient, parent, or guardian