*PLEASE ANSWER EACH QUESTION & COMPLETE BOTH SIDES*

Separated ❑ Widowed ❑
Divorced ❑ Single ❑
Child ❑ Married ❑

## PATIENT INFORMATION

NAME _____ BIRTH DATE _____ SEX _____
SOC. SEC. NO _____ HOME PHONE _____
EMAIL _____ CELL PHONE _____
Address _____ CITY _____ ZIP _____
SCHOOL (If full time student) _____ CITY _____ ZIP _____
PREVIOUS DENTIST _____ CITY _____ LASTVISIT_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

## PERSON RESPONSIBLE FOR ACCOUNT

NAME (Head of Household) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____PHONE _____+_____
NAME (Spouse of Head of Household) _____
CCUPATION _____SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE _____

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, or his qualified designate. I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, **at the time of service**, unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a Service charge of 1 1/2 % per month (18% annual percentage rate), and I am responsible for attorney's fee, collection fees, or court costs incurred in the collection of delinquent account. I understand that where appropriate, a credit check may be made through a credit bureau.

Signed: Patient, Parent or Agent _____ Date: _____

Relationship to Patient _____

## FOR PATIENTS WITH DENTAL INSURANCE

INSURED PERSON'S NAME _____ BIRTH DATE _____
INSURANCE COMPANY _____GROUP NO. _____ID#. _____
INSURED PERSON'S NAME (If dual ) _____ BIRTH DATE_____
INSURANCE COMPANY _____GROUP NO. _____ID#._____
RANCE COMPANY ADDRESS _____

INSURANCE RELEASE

AUTHORIZATION TO PAY AND TO RELEASE INFORMATION. I hereby authorize insurance benefit payments directly to Dr. Licking for services. I am financially responsible for the changes not covered. A copy of this authorization shall be as valid as the original. I also authorize Dr. Licking to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

Signed: Patient, Parent or Agent _____ Date: _____

Relationship to Patient _____

*PLEASE COMPLETE REVERSE SIDES*

Why did you leave your last dentist?
What did you like least about your last dentist?
What di you like most about any dental office you have gone to?
What are you expecting to have done today?
Are you having any dental pain or discomfort at this time?
Are you happy with your smile?
If you could change one thing about your smile what would it be?
Initial to authorize Dr. Licking to use your x-ray or photographs for teaching purpose.

## FOR PATIENTS WITH DENTAL INSURANCE

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____

NAME OF PHYSICIAN _____

YES NO

❒ ❒ Are you now or have you been under the care of a physician with the past two years? _____

❒ ❒ Are you pregnant? Month: _____

❒ ❒ Are you now or have you recently been taking any medication? _____

❒ ❒ Have you experienced any ill effects or allergy to **ANY** medication? (pencillin, novacaine, codeine, aspirin, linseed, olive, or avacado oil, etc.) _____

❒ ❒ Have you ever had a skin reaction to any metal? _____

❒ ❒ Do you grind or clench your teeth? _____

❒ ❒ Have you had any major surgery or hospitalization? _____ Date _____

HAVE YOU HAD:

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❒ | ❒ | Heart Failure | ❒ | ❒ | Heart Pacemaker | ❒ | ❒ | Sinus Trouble | ❒ | ❒ | Drug Addiction |
| ❒ | ❒ | Heart Disease or Attack | ❒ | ❒ | Heart Surgery | ❒ | ❒ | Diabetes | ❒ | ❒ | Cold Sores |
| ❒ | ❒ | Angina Pectoris | ❒ | ❒ | Artificial Joint | ❒ | ❒ | Cancer | ❒ | ❒ | Fainting/Dizzy Spells |
| ❒ | ❒ | High Blood Pressure | ❒ | ❒ | Mitral Valve Prolapse | ❒ | ❒ | Glaucoma | ❒ | ❒ | Bleeding Gums |
| ❒ | ❒ | Heart Murmur | ❒ | ❒ | Stroke | ❒ | ❒ | Pain in Jaw Joints | ❒ | ❒ | Bad Breath |
| ❒ | ❒ | Rheumatic Fever | ❒ | ❒ | Kidney Trouble | ❒ | ❒ | Epliepsy or Seizures | ❒ | ❒ | Chronic Headaches |
| ❒ | ❒ | Congenital Heart Defect | ❒ | ❒ | Ulcers | ❒ | ❒ | AIDS | ❒ | ❒ | Blood Disorder |
| ❒ | ❒ | Scarlet Fever | ❒ | ❒ | Tuberculosis (TB) | ❒ | ❒ | Hepatitis | ❒ | ❒ | Tuberculosis (TB) |
| ❒ | ❒ | Artificial Heart Valve | ❒ | ❒ | Asthma | ❒ | ❒ | Liver Disease | | | |

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform this office at the next appointment wihout fail.

Date _____ Signature of Patient, Parent or Guardian _____

Relationship to patient _____

## ACKNOWLEDGEMENT
## of Receipt of Notice of Privacy Practice

As required by the Privacy Regulations, I hereby aknowledge that I have received a current copy of Dr. Licking's "NOTICE OF PRIVACY PRACTICES". This Notice provides information about how my protected health information may be used or disclosed.

Patient (or Representative ) Signature _____Date _____

If signed by other than patient, print name and relationship

Name _____ Relationship _____

### INABILITY TO OBTAIN ACKNOWLEDGEMENT
(Complete only if No Signature is Obtained)

A good faith effort has been made to obtain the acknowledgement above. At this time the following circumstances exist:

❒ The patient is not able to sign and there is no legal representative availbe
❒ The patient refuses to sign

Signature of Employee _____ Date _____