PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential forms.
The information provided is important to your dental health.

Patient's name ______________________ Preferred name ____________ Birth date__________

If minor, parents names ____________________ Home phone __________ Work phone __________

Mailing address ______________________ City ____________State ______ Zip ________

Email address ____

Employer ____________________ Occupation ____________________________

Spouse's name __________________ Spouse's employer ____________________ ❑ Unmarried

How did you hear about us? ______________________________________

EMERGENCY CONTACT ________________Phone Number________________

Previous Dentist Name__________________ Phone Number________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co.____________ Policy/Social Security #: ___________ Group number________

Covered by spouse's insurance? ❑ Yes ❑ no

Spouse's dental insurance company ____________ Group number __________

Spouse's birthday ____________ Policy/Social Security number ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer, tumor, radiation or chemotherapy
- ❑ Heart attack, ailment, angina, or stroke
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker or defibrillator
- ❑ Tuberculosis, emphysema, chronic cough or lung disease
- ❑ Kidney disease
- ❑ Hepatitis, jaundice, or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, dizziness, or fainting spells
- ❑ Emotional condition, anxiety, nervousness
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia, bruises easily, or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ Yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:______________________
____

Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician: ______________________________________

Do you have any disease, condition, or problem not listed above? ______________________
____

Please add anything else you would like us to know about: ______________________

DENTAL HEALTH HISTORY

Do you have or have you had any of the following?

- ❑ Bad tastes or mouth odor?
- ❑ Frequent cold sores, blisters, or other oral lesions?
- ❑ Sore or bleeding gums?
- ❑ Loose teeth or changes in your bite?
- ❑ Frequently get food caught between your teeth?
- ❑ Have parents who have gum disease or tooth loss?
- ❑ Clinch or Grind teeth while awake or asleep?
- ❑ Bite lips or cheeks regularly?
- ❑ Hold objects with your teeth (pens, pencils, nails)?
- ❑ Mouth breathes while awake or sleeps?
- ❑ Use two pillows while sleeping?

In the past 6 months have you had any of the following?

- ❑ Clicking or popping of jaw?
- ❑ Pain (joint, ear, side of face)?
- ❑ Difficulty opening or closing your mouth?
- ❑ Difficulty chewing on either side of your mouth?
- ❑ Head, neck, or shoulder aches?
- ❑ Tired jaws, especially in the morning?

Are any of your teeth sensitive to:

- ❑ Hot or Cold
- ❑ Sweets
- ❑ Biting or Chewing
- ❑ Other:____

Have you had any of the following?

- ❑ Oral Surgery
- ❑ Periodontal Treatment
- ❑ A serious head or mouth injury
- ❑ Orthodontic Treatment
- ❑ Teeth ground down or adjusted
- ❑ A bite plate or mouth guard

Are you nervous about receiving dental treatment?
❑ Yes ❑ no

Have you ever had an upsetting dental visit? If so please describe____

Are you satisfied with the way your teeth look?
❑ Yes ❑ no

Would you like to keep your teeth all of your life?
❑ Yes ❑ no

The information on both sides of this form is true to the best of my knowledge. If further information is needed I give this office my permission to contact the respective health care providers to release such information. I hereby authorize the doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I further authorize and consent that the doctor choose and employ such assistance deemed fit. I understand it is my responsibility to notify the doctor of any changes in my health or medication on an ongoing basis. I authorize this office to submit claims for payment to the insurance company named above, for services rendered. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier. I understand that payment is due and payable at the time services are rendered unless other financial arrangements have been made with this office. In the event payments are not received by agreed upon dates, I understand that a 1 ½% finance charge may be added to my account, (18% annual). I further authorize this office to provide any insurance company, health care service plan, self-insurers, or their representatives, any and all information and records about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

Signature of Patient or Patient's Guardian____ Date __________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____have received a copy of this office's Privacy Practices.

Print Name______________________________________Signature______________________________Date_________

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other ________________________________