

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes No Thank you.

<div data-bbox="64 504 162 630"> <h2>1</h2> </div> <div data-bbox="276 556 690 609"> <h3>Patient Information</h3> </div> <p>Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p>_____</p> <p>City State Zip</p> <p>I prefer to be called: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other</p> <p>Birthdate _____ Gender: F <input type="checkbox"/> M <input type="checkbox"/> Age _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient SS# _____ - _____ - _____</p> <p>If patient is a minor, give parent's or guardian's name: _____</p> <p>Occupation _____</p> <p>Spouse's Name _____</p> <p>Spouse's Occupation _____</p> <p>Spouse's Employer _____</p> <p>Whom may we thank for referring you? _____</p>	<div data-bbox="803 504 901 630"> <h2>3</h2> </div> <div data-bbox="974 556 1323 609"> <h3>Phone Numbers</h3> </div> <p>Home Phone _____</p> <p>Work _____ Ext. _____</p> <p>Cell Phone # _____</p> <p>Spouse's Work _____</p> <p>Best time and place to reach you: _____</p> <p>Family Physician's Name: _____</p> <p>Physician's Phone: _____</p> <p>IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home Phone _____</p> <p>Work Phone _____</p>
<div data-bbox="64 1333 162 1459"> <h2>2</h2> </div> <div data-bbox="300 1375 657 1428"> <h3>Dental Insurance</h3> </div> <p>Who is responsible for this account? _____</p> <p>Who is the subscriber for this insurance? _____</p> <p>Subscriber place of employment? _____</p> <p>SS# _____ - _____ - _____ Birthdate _____</p> <p>Relationship to Patient: _____</p> <p>Insurance Co. _____</p> <p>Group #. _____</p> <p>Is patient covered by additional insurance? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Subscribers Name: _____</p> <p>Insurance Co. _____</p> <p>Group #. _____</p>	<div data-bbox="803 1333 901 1459"> <h2>4</h2> </div> <div data-bbox="941 1354 1453 1396"> <h3>ASSIGNMENT AND RELEASE</h3> </div> <p>I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>_____</p> <p>Responsible Party Signature</p> <p>_____</p> <p>Relationship to Minor (if applicable) Date</p>

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Dental History

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

- Bad Breath Yes No
- Bite your lips or cheeks regularly Yes No
- Bleeding gums Yes No
- Blisters on lips or mouth Yes No
- Chew on one side of mouth Yes No
- Dry mouth Yes No
- Food collection between the teeth Yes No
- Grinding teeth Yes No
- Gums swollen or tender Yes No
- Jaw pain or tiredness Yes No
- Mouth breathing Yes No
- Orthodontic treatment Yes No
- Pain around ear Yes No
- Periodontal (gum) treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to hot Yes No
- Have you experienced:*
- Clicking or popping of the jaw? Yes No
- Pain? (Joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics before dental treatment?

Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problems associated with any previous dental work?

Yes No

Do you like your smile? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? _____

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Medical History

Your current physical health is:

Good Fair Poor

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

Please explain: _____

Are you taking any prescription / over the counter drugs? Yes No

Please list each one _____

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

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Do you have or have you ever had any following diseases or medical problems?

Abnormal Bleeding Yes No

Alcohol / Drug Abuse Yes No

Alzheimer's Disease Yes No

Anemia Yes No

Arthritis Yes No

Artificial Bones Joints Valves Yes No

Asthma Yes No

Blood Transfusion Yes No

Bruise Easily Yes No

Cancer / Chemotherapy Yes No

Collitis Yes No

Diabetes Yes No

Difficulty Breathing Yes No

Emphysema Yes No

Epilepsy Yes No

Fainting Spells Yes No

Frequent Headaches Yes No

Glaucoma Yes No

Hay Fever Yes No

Heart Problems Yes No

Heart Murmur Yes No

Hemophilia Yes No

Hepatitis Yes No

Herpes/Fever Blisters Yes No

High Blood Pressure Yes No

HIV+ / AIDS Yes No

Hospitalized for Any Reason

Yes No

Joint Replacement Yes No

Kidney Problems Yes No

Liver Disease Yes No

Low Blood Pressure Yes No

Mitral Valve Prolapse Yes No

Nervous/Anxious Yes No

Pacemaker Yes No

Psychiatric/Psychological Care Yes No

Radiation Treatment Yes No

Rheumatic/Scarlet Fever Yes No

Seizures Yes No

Sinus Problems Yes No

Stroke Yes No

Thyroid Problems Yes No

Tuberculosis (TB) Yes No

Tumors or Growths Yes No

Ulcers Yes No

Venereal Disease Yes No

Do you have or have you had any disease, condition, or problem not listed? Yes No

Are you allergic to any of the following?

Aspirin Yes No

Codaine Yes No

Dental Anesthetics Yes No

Latex Yes No

Metals Yes No

Penicillin Yes No

Tetracycline Yes No

Please list any other drugs/materials that you are allergic to: _____

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CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____

Date _____

**HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please print your name

Please sign your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- | | |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from those affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

Signature of Privacy Officer

PATIENT INFORMATION:

PATIENT EMAIL: _____

PREFERRED PHARMACY: _____

***PHARMACY ADDRESS:** _____

***PHARMACY PHONE NUMBER:** _____