

PATIENT INFORMATION

Date _____ Occupation _____

SS/HIC/Patient ID# _____ Patient Employer / School _____

Patient Name _____ Employer / School Address _____

Address _____

City _____ Employer / School Phone _____

State _____ Zip _____ Spouse's Name _____

E-mail _____ Birth Date _____ SSN _____

Sex M F Age _____ Birth Date _____ Spouse's Employer _____

Married Widowed Single Minor Whom may we thank for referring you? _____

Separated Divorced Partnered _____

DENTAL INSURANCE

Subscriber's Name _____ Is patient covered by secondary insurance? Yes No

Relationship to Patient _____ Subscriber's Name _____

Birth Date _____ SSN _____ Relationship to Patient _____

Insurance Co. _____ Birth Date _____ SSN _____

Group # _____ Phone _____ Insurance Co. _____

Group # _____ Phone _____

PHONE NUMBERS

Home _____ Spouse's Work _____

Work _____ Spouse's Cell _____

Cell _____

In case of emergency, contact
(someone who does not live in your household)

Name _____ Relationship _____

Home _____ Cell _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental X-rays _____

_____ How often do you floss? _____

Former Dentist _____ How often do you brush? _____

City / State _____ Do you wear contact lenses? Yes No

Date of last dental visit _____

Please check "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of the mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone _____ Pharmacy _____ Phone _____

Please check "yes" or "no" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had or been	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	diagnosed with:	
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints, Screws, Pins, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding abnormally,	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	w/ extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet/Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia Repair	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL HISTORY (continued)

Have you ever had any complications

following dental treatment? Yes No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? Yes No

If yes, please describe _____

Women: Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Have you ever taken any of these medications?

Blood Thinners Yes No

Coumadin Yes No

Warfarin Yes No

Diet Medications Yes No

Dexfenfluramine Yes No

Fen-phen Yes No

Pondimin Yes No

Redux Yes No

Levoxyl Yes No

Synthroid Yes No

Are you allergic to:

Aspirin Yes No

Barbiturates Yes No

Codeine Yes No

Ibuprofen Yes No

Latex Yes No

Local Anesthesia Yes No

Metals (i.e. gold) Yes No

Penicillin Yes No

Other _____

Please PRINT all medications now taking: _____

SIGNATURES

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I and/or my dependent (s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered.

Name of Insurance Company(ies)

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (es) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers.

I voluntarily authorize: Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____

Name of Doctor Disclosing PHI

Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed

The information will be used and/or disclosed for the purpose of _____

Describe each purpose for which you are authorizing

_____. I authorize Dr. _____ to receive and use the information.

your protected Health Information to be used and/or disclosed

Name of Doctor Disclosing PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

HIPPA PATIENT CONSENT FORM

I understand that ,under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information .I understand that this information can and will be used to :

- Conduct ,plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly & indirectly .
- Obtain payment from third party payors .
- Conduct normal healthcare operations such as quality assessments and physician certifications .

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information .I have been given the right to review such Notice of Privacy Practices prior to signing this consent .I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices .

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment ,payment of healthcare operations .I also understand that you are not required to agree to my requested restrictions ,but if you do agree then you are bound to abide by such restrictions .

I understand that I may revoke this consent in writing at any time ,except to the extent that you have taken by relying on this consent .

Patient Name : _____

Signature : _____

Relationship to Patient : _____

Date : _____