Patient Basic Information

Legal First Name_____ Nickname_____

Middle Initial_____ Last Name_____

Birth Date_____ Gender _____

SSN_____ Martial Status _____

Patient Contact Information

Address_____ Suite/Apt_____

City _____State_____ Zip code_____

EMAIL _____

Home Phone _____ Cell Phone _____

Who is responsible for account? _____ Relationship: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

Patient Primary Insurance

Subscriber (Insured) Employer _____

Subscriber Name _____ D.O.B _____

Social Security # _____

Insurance Co._____ Phone # _____

ID # _____ Group # _____

Secondary Insurance(if applicable)

Subscriber (Insured) Employer _____

Subscriber Name _____ D.O.B _____

Social Security # _____

Insurance Co._____ Phone # _____

ID # _____ Group # _____

HIPAA Information and Consent

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A notice of Privacy practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices, which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change out notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

Name_____ Date _____

Medical and Dental Information

If you are completing this for another person besides yourself, what is your relationship to that person

Your Name: _____

Relationship: _____

Medical Doctor's Name: _____ City: _____

Are you now under the care of a physician? YES NO

Do you have, or have you had any of the following:

☐ Anemia	☐ Diabetes	☐ HIV/AIDS	☐ Swelling of feet or ankles
☐ Arthritis	☐ Epilepsy	☐ Jaw Pain	☐ Thyroid Problems
☐ Artificial Heart Valves	☐ Fainting	☐ Kidney Disease	☐ Tobacco Habit
☐ Artificial Joints	☐ Glaucoma	☐ Liver Disease	☐ Tuberculosis
☐ Asthma	☐ Headaches	☐ Mitra Valve Prolapse	☐ Ulcer
☐ Back Problems	☐ Heart Murmur	☐ Pace Maker	☐ Venereal Disease
☐ Blood Disease	☐ Heart Problems	☐ Respiratory Disease	☐
☐ Cancer	☐ Hemophilia	☐ Rheumatic Fever	☐
☐ Chemical Dependency	☐ Hepatitis	☐ Shortness of Breath	☐
☐ Circulatory Problems	☐ High Blood Pressure	☐ Stroke	☐ Other_____

History of other serious illness, hospitalization or accident? _____

Do you have additional medical conditions or concerns? _____

Have you had any changes in your general health lately? _____

Have you ever taken an antibiotic prior to dental treatment? (If yes, please list type)

_____

Medication Reconciliation

Current Medications you are Taking:

_____

Allergies

Do you have any allergies : YES NO

If yes , please list: _____

Bisphosphonates (Medications used to treat osteoporosis and similar diseases.)

Have you ever taken these medications: YES NO
If yes ,please circle
Alendronate (fosamax) Risedronate (actonel) bandronate (Boniva)

Smoking Status

Do you currently smoke: YES NO

Women

Are you pregnant or suspect you may be: YES NO

Dental History

When was your last dental visit? _____

How frequently do you brush your teeth? _____

How frequently do you floss your teeth? _____

What is the nature of today's visit? _____

Are you nervous about dental treatment? _____

Have you ever had orthodontic treatment? _____

Are you happy with your smile? YES NO

Do you clench or grind your teeth? YES NO

Have you ever been treated for gum disease? YES NO

Do your gums bleed when you brush or Floss? YES NO

Are any of your teeth currently causing you pain? YES NO

Have you ever had any periodontal treatment? YES NO

Are you concerned with loose teeth or teeth loosening? YES NO

Do you have any dental implants, dentures, or partials? YES NO

Have you been told you snore? YES NO
If yes, please comment: _____

Have you been treated for Sleep Apnea? YES NO
If yes, please comment: _____

How Did You Hear About Us?

How did you hear about us? _____