



PERSONAL INFO

DATE: _____ E-MAIL ADDRESS: _____

PATIENT'S FULL NAME: _____

PREFERRED NAME: _____ BIRTHDATE: _____ SS# _____

MALE / FEMALE

SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

HOME ADDRESS: _____

HOME #: _____ CELL #: _____

PARENT/GUARDIAN (if child) _____

EMPLOYER: _____

PHONE#: _____ OCCUPATION: _____

EMERGENCY CONTACT & PHONE # _____

INSURANCE INFO

PRIMARY DENTAL INSURANCE: _____

ADDRESS: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER ID #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S BIRTHDATE: _____ RELATIONSHIP(to patient): _____

SUBSCRIBER'S EMPLOYER: _____

Patient Initials: _____

SECONDARY DENTAL INSURANCE: _____

ADDRESS: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER ID #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S BIRTHDATE: _____ RELATIONSHIP(to patient): _____

SUBSCRIBER'S EMPLOYER: _____

MEDICAL INFO

Please circle all that pertain to you:

Are you allergic to any of the following?

Aspirin	Erythromycin	Codeine	Latex	Dental Anesthetics
Penicillin / Amoxicillin		Tetracycline		Metals / Jewelry
Sulfa	Other _____			None

Have you ever had any of the following diseases or medical problems?

Abnormal bleeding	Hay fever	Mitral valve prolapse
Alcohol/drug abuse	Heart attack	Pacemaker
Anemia	Heart murmur	Psychiatric disorders
Arthritis	Heart Surgery	Radiation or chemotherapy
Artificial joints/valves	Hemophilia	Rheumatic/scarlet fever
Asthma	Hepatitis	Seizures-date of last _____
Blood transfusion	Herpes/fever blisters	Shingles
Cancer (type) _____	High blood pressure	Sickle cell disease
Colitis	HIV +/-AIDS	Sinus problems
Congenital heart defect	Frequent headaches	Stroke (date) _____
Difficulty breathing	Kidney disease	Tuberculosis(TB)
Emphysema	Liver disease	Ulcers
Epilepsy	Low blood pressure	Venereal disease
Fainting spells	Glaucoma	Thyroid problems:
Blood thinners	Hospitalized	-Hyper or Hypo?
Diabetes-last HBA1C _____	None	Other _____
-today's blood sugar _____		

*If you've answered yes to chemo/radiation, when were the last dates of treatment? _____

Dr. Signature: _____

Patient Initials: _____

Please list any prescription & over the counter meds you are taking: (you may provide a list)

Have you ever taken Fosamax, or any other bisphosphonate (for bone loss)? YES NO

Have you ever taken Phen-fen? YES NO Are you taking birth control pills? YES NO

Are you pregnant? YES #of weeks _____ NO Are you nursing? YES NO

DENTAL HISTORY

PREVIOUS DENTIST & PHONE #: _____

Do you require antibiotics(PRE-MED) for dental treatment?(artificial joints/valves) YES or NO

Are you currently in pain? YES NO Do your gums bleed? YES NO

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

YES NO

Do you now or have you ever experienced pain in your jaw joint(TMJ)? YES NO

Your current dental health is: GOOD FAIR POOR

Do you like your smile? YES NO Do you use tobacco? YES NO

Would you like whiter teeth? YES NO Fresher breath? YES NO

How many times a week do you floss? _____ How many times a day do you brush? _____

Type of bristles on your toothbrush? SOFT MEDIUM HARD

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to preform any necessary dental services that I may need during diagnosis & treatment with my informed consent. I understand that I am responsible for payment of services rendered & also responsible for paying any copayments & deductibles that my insurance does not cover. PAYMENT IS DUE AT TIME OF TREATMENT. There may be a \$25 fee for any no showed or appointment cancelled without a 36 hour notice.

Patient/GUARDIAN SIGNATURE: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information. The notice contains a patient's right under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member or your family? YES NO

If YES, please name the members allowed:

Our office participates with a texting & appointment confirmation patient communication service. By signing this consent, you are giving our office permission to use these services. You may opt out at anytime by letting us know if you no longer wish to communicate with us this way.

This consent was signed by: _____

(please print)

Signature: _____ Date: _____