Welcome

Patient Information Today's Date___/___/___ Male___ Female___

Name_____

Address_____ City, State, Zip _____

Date of Birth_____ Social Security #____-___-____ Email_____

Which number do you prefer to be contacted (check below)? Can you be contacted at work? □ Yes □ No

□ Home Number_____ □ Cell _____ □ Work _____

Employer_____

Parent or Spouse's Name_____

Address _____ Phone Number _____

Dental Insurance Information

Name of Primary Insurance_____ Relationship to Patient_____

Date of Birth of Insured_____ Social Security # of Insured ____-____-_____

Employer_____ Employer Phone # _____

Name of Dental Insurance Carrier _____

Dental Insurance Claim Address & Phone # _____

ID Number _____ Group Number _____

Do you have secondary dental insurance? □ Yes □ No

If so, please complete the following information:

Name of Secondary Insurance_____ Relationship to Patient_____

Date of Birth of Insured_____ Social Security # of Insured ____-____-_____

Employer_____ Employer Phone # _____

Name of Dental Insurance Carrier _____

Dental Insurance Claim Address & Phone # _____

ID Number _____ Group Number _____

Responsible Party

Person Responsible for this Account _____

Relationship to Patient _____ Social Security # ____-____-_____

Address_____ City, State, Zip _____

Home Phone_____ Cell _____ Work_____

Employer _____

Who may we thank for referring you to our office? _____

Personal Information

Patient Name_____ Birthdate_____ Today's date_____
Cell Phone _____Work Phone _____ Employer Name_____
Home Address _____ City/ Zip Code_____
Emergency Contact Name & Number/ Relation_____
Dental Insurance Yes No Insurance Company_____
Please list all the **names** and **phone numbers** of the physicians currently providing your care:

1. _____
2. _____
3. _____

Date of last ***medical*** exam: _____ What was this exam for? _____
Have you been hospitalized in the last 5 years? Yes No If yes, reason_____
What pharmacy do you use & phone number _____
If you are a new patient, please list your previous dentist: _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Abnormal Bleeding	Yes	No	Fever Blisters	Yes	No	HIV/ Aids	Yes	No
Alcohol or Drug Use	Yes	No	Glaucoma	Yes	No	Joint Replacement	Yes	No
Allergies	Yes	No	Headaches	Yes	No	Kidney Disease	Yes	No
Anemia	Yes	No	Heart Attack	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Heart Surgery	Yes	No	Psychiatric/ Mental Health	Yes	No
Asthma	Yes	No	Congenital Heart Disease	Yes	No	Radiation/Chemotherapy	Yes	No
Blood Transfusion	Yes	No	Mitral Valve Disease	Yes	No	Rhematic Fever	Yes	No
Cancer/ Biopsies	Yes	No	Pacemaker	Yes	No	Shingles	Yes	No
Diabetes	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Emphysema/ Respiratory	Yes	No	High/Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Epilepsy/ Seizures	Yes	No	Hemophilia	Yes	No	Tuberculosis	Yes	No
Fainting Spells	Yes	No	Hepatitis A/B	Yes	No	STDs	Yes	No

Has your medical doctor required you to pre-medicate to dental treatment? Yes No

Women: Are you Pregnant? Yes No Are you a nursing mother? Yes No
Are you taking prescription birth control? Yes No

Are you allergic to or have you had reactions to:

a. Aspirin Yes No b. Penicillin Yes No c. Latex Yes No
d. Dental Anesthetic Yes No e. Narcotics Yes No f. Sulfa Yes No
g. Other _____

Are you a tobacco or vape user? Yes No If yes, how much per day_____

Any other importance in your medical history? _____

Please list all the medications you are currently taking.

1._____ 4._____
2._____ 5._____
3._____ 6._____

Initials _____ Date _____

ACKNOWLEGMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA) &

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By initialing this form, you acknowledge that you have been offered a copy of the HIPPA privacy policy, which explains how your health information will be handled in various situations. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically.

Initials _____________ Date__________________

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We value and do everything to protect your privacy. Your medical and dental information will not be given to any individual (including spouses, parents, children, or any significant others) without your written consent. If you want anyone to have access to your medical or dental information, please list their name, relation and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency)

Name_____________________________ Relation______________ Phone_________________

Name_____________________________ Relation______________ Phone_________________

Name_____________________________ Relation______________ Phone_________________

Name_____________________________ Relation______________ Phone_________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication

Signature_______________________________________ **Date**__________________________

Printed Name___________________________________