Patient Information (CONFIDENTIAL)

How did you hear about us? ______________________

We can now confirm appointments by email or text message. please check your preference:

❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you willing to be on a quick-fill list? ❑ Yes ❑ No

Patients receive a 10% discount off treatment or $20 credit for routine exam/cleaning when taking a quick fill appointment. You may receive numerous phone calls when there are cancellations.

Name ______________________ Birthdate __________ Home Phone __________ ❑ M ❑ F

Address ______________________ City ______________ State ______ Zip ______

Email ______________________ SS#______________ Cell Phone ______________

If Full Time Student, Name of School/College ______________ City ______________ State ______

Patient or Parent/Guardian's Employer ______________________ Work Phone ______________

Business Address ______________________ City ______________ State ______ Zip ______

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone ______________

Person to contact in case of emergency ______________________ Phone ______________

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account ______________________ Relationship to Patient ______________

Address ______________________ Home Phone ______________

Birthdate ______________Email ______________________ Cell Phone ______________

Employer ______________________ Work Phone ______________ SS#______________

Patient Dental History

Name of Previous Dentist and Location ______________________Date of Last Exam ______________

1. Have you ever been diagnosed with periodontal disease?______________________

____

2. Do you like your smile? __________ How would you rate your smile on a scale from 1-10?__________

3. What changes would you make to improve your smile?______________________

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured ______________________

Relationship to Patient ______________________

Birthdate ______________________

SS#/ID# ______________________

Name of Employer ______________________

Insurance Company ______________________

Group # ______________________

Policy ID # ______________________

SECONDARY INSURANCE

Name of Insured ______________________

Relationship to Patient ______________________

Birthdate ______________________

SS#/ID# ______________________

Name of Employer ______________________

Insurance Company ______________________

Group # ______________________

Policy ID # ______________________

Over Please...

Patient Medical History

Physician ____________________ Office Phone ____________ Date of Last Exam ________

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑

If yes, please explain: ____________________

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking? ____________________

	Yes	No
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	❑	❑

If yes, for what reason? ____________________

5. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (Please list)	❑	❑

	Yes	No
6. Do you use tobacco?	❑	❑
7. Do you use controlled substances?	❑	❑
8. **Are you taking any blood thinners?**	❑	❑
9. **Are you taking any bone strengthening medications (bisphosphonates)?**	❑	❑
10. Do you have Hepatitis or Jaundice?	❑	❑
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑

12. Do you have or have you had any of the following?

	Yes	No
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Cardiac Pacemaker	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Epilepsy/Convulsions	❑	❑
Fainting/Seizures	❑	❑
Heart Attack Date: ________	❑	❑
Heart Disease	❑	❑
Heart Murmur	❑	❑
Heart Trouble	❑	❑
High Blood Pressure	❑	❑
Joint Replacement or Implant Date: ________	❑	❑
Kidney Disease	❑	❑
Leukemia	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Mitral Valve Prolapse	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Rheumatic Fever	❑	❑
Stroke Date: ________	❑	❑
Thyroid Problem	❑	❑
Tuberculosis	❑	❑
Other (please list)	❑	❑

13. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

HIPAA Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient *(or Parent/Guardian of Minor)* ____________________ Date ________

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following: ____________________

Signature of Patient *(or Parent/Guardian of Minor)* ____________________ Date ________