Date:_____

Patient Information

Last Name:_____ Legal First Name:_____ MI:_____

Preferred First Name:_____

Birth date:_____ Age:_____ SSN:_____

Home:_____ Cell:_____ Email:_____

Address:_____ City:_____ ST_____ Zip_____

Employer:_____ Occupation:_____

Emergency Contact: _____ Ph:_____

Relationship to Patient:_____

Spouse/Parent Information

Last Name:_____ First Name:_____ MI:_____

Birth date:_____ Age:_____ SSN:_____

Home:_____ Cell:_____ Email:_____

Address:_____ City:_____ ST_____ Zip_____

Employer: _____ Occupation:_____

Referral Information

How did you hear about our office? (*Circle One)*

Personal Referral Phone Book Internet Newspaper Radio Ad Insurance Provider Other

Name of referral or explain Other: _____

Insurance Information

Subscriber Name:_____ Birth date_____

Subscriber ID (*Sometimes this is the Social Security Number)*:_____

Subscriber Employer:_____ Group Number:_____

Your relationship to the subscriber:_____

Name of Dental Insurance Provider: _____ Phone:_____

Medical Information

Are you under the care of a physician for any condition? If so, for what condition?

_____

_____

Physician Name:_____ Phone:_____
Has there been any change in your general health over the last year?_____

List any medications, prescription or over the counter:

_____
_____
_____
_____

Do you have any Artificial Joints? Which/When Replaced? _____

Do you use Tobacco? Y N If yes, what kind:_____ How Often:_____

Allergies:

Local Anesthetic	Y N	Metal	Y N
Latex	Y N	Rubber	Y N
Aspirin	Y N	Iodine	Y N
Penicillin or other antibiotic	Y N	Seasonal	Y N
Sulfa	Y N	Food: _____	
Codeine or other narcotic	Y N	Other: _____	

Please Indicate if you have any of these conditions: (*circle Y or N for each item)*

Autoimmune Disease	Y N	Rheumatoid Arthritis	Y N
Arteriosclerosis	Y N	Lupus	Y N
Heart Attack	Y N	Asthma	Y N
Heart Murmur	Y N	Emphysema	Y N
High Blood Pressure	Y N	Rheumatic Fever	Y N
Pacemaker	Y N	Abnormal Bleeding	Y N
Tuberculosis	Y N	Hemophilia	Y N
Cancer	Y N	AIDS/HIV	Y N
Chest Pain	Y N	Eating Disorder	Y N
Diabetes	Y N	Ulcers	Y N
Reflux/Heartburn	Y N	Hepatitis	Y N
Epilepsy	Y N	Mental Health Disorder :_____	
Osteoporosis	Y N		
Congenital Heart Disease	Y N		
Artificial Heart Valve	Y N		
Damaged Heart Valve/Artificial Heart	Y N		

Have you ever been told you need to take a Pre-Medication prior to dental treatment? **Y N**
If yes, why were you told that and what medication do you normally take?

_____

_____

Dental Information

Do your gums bleed when brushing or flossing	Y N
Are your teeth sensitive to hot, cold, sweets or temperatures?	Y N
Does food or floss catch between your teeth?	Y N
Is your mouth dry?	Y N
Have you ever had periodontal (gum) treatments?	Y N
Have you ever had orthodontic (braces) treatment?	Y N
Have you ever had any problems with previous dental treatments?	Y N
Is your water fluoridated?	Y N
Are you currently having any dental discomfort?	Y N
Do you have ear/neck aches?	Y N
Do you have any clicking, popping, grinding in your jaw?	Y N
Do you clench or grind your teeth?	Y N
Do you get sores or ulcers in your mouth?	Y N
Do you wear dentures or partials?	Y N
Have you ever had any serious injury to your head or mouth?	Y N

What was the date of your last dental exam?_____ _____ X rays?_____

What was done at that visit? _____

_____

What is the reason for your visit today? _____

_____

How do you feel about your smile? (ie: color of teeth, crooked teeth, missing teeth, pain, etc.)

_____

_____

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and 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 the tat treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Contact patient or guardian via phone, email, or text regarding scheduling, account, or treatment.

Individuals authorized to communicate on my behalf are as follows:

1. First & Last Name:_____ Birth Date:_____
   Relationship to patient:_____ Phone Number:_____
   May communicate (Circle all that apply):
   Appointments Treatment Insurance & Account Information Medical Information

2. First & Last Name:_____ Birth Date:_____
   Relationship to patient:_____ Phone Number:_____
   May communicate (Circle all that apply):
   Appointments Treatment Insurance & Account Information Medical Information

3. First & Last Name:_____ Birth Date:_____
   Relationship to patient:_____ Phone Number:_____
   May communicate (Circle all that apply):
   Appointments Treatment Insurance & Account Information Medical Information

I have received (*or been offered*), read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 at the address above 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 or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____
Relationship to Patient:_____
Signature:_____ *Date*:_____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below.
Date:_____Initials:_____Reason:_____