Patient Information Date: _____/_____/_____

Name: ____ ☐Married ☐Single ☐Minor ☐Male ☐Female

Last First MI

Address: ____

Street App/Unit# City State Zip

Birth Date: ____/____/______ Home Phone: __________________ Work/Mobile Phone: ____________________

mm/dd/yyyy

Place of Employment: ____ SS #: _____________________________________

If Full Time Student, School Name: ____ Grade: ________________________

Dental Insurance Company: _________________________ Subscriber #: __________ Group #:________

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

Whom may we thank for referring you to our office? ____

Family Information

Father (or Husband)

____
Last First MI

____
Street City State Zip

____
Home Phone # Work/Mobile Phone #

____
Birth Date (mm/dd/yyyy) SS#

____
Employer

____
Dental Insurance Co. Subscriber # Group #

Mother (or Wife)

____
Last First MI

____
Street City State Zip

____
Home Phone # Work/Mobile Phone #

____
Birth Date (mm/dd/yyyy) SS#

____
Employer

____
Dental Insurance Co. Subscriber # Group #

Person to Contact in Case of Emergency
Outside of Immediate Family / Household
Name: ____
Address: ____
City/State/Zip: ____
Telephone #: ____

Authorization
I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.
X ____
__Adult Patient __Father/Husband __Mother/Wife __Guardian

Date: ____
State Driver's License #: ________________________________

Person Responsible for Account
Please Check One
☐Patient ☐Father (or Husband)
☐Guardian ☐Mother (or Wife)

Method of Payment
Responsible party currently has an account with this office
☐Yes ☐No
☐Payment in Full at each appointment (cash or personal check)
☐Payment in full at each appointment VISA MC
Card #: ________________________________Exp. Date:_______
☐I wish to discuss the Dental Office's Financial Policy

Service Charge
If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient Name: ____ Date _______ / _______ / _______

Primary reason for this dental appointment: ____ Examination ____ Emergency ____ Consultation

Dental History

Do you have a specific dental problem? Describe: ___________________________________	☐Yes	☐No
Do you have a dental examination on a routine basis? Last Visit: ________________________	☐Yes	☐No
Do you think you have active gum decay or gum disease?	☐Yes	☐No
Do you brush and floss on a routine basis?	☐Yes	☐No
Do your gums ever bleed? Describe: ____	☐Yes	☐No
Do you like your smile? If not, why? ____	☐Yes	☐No
Does food catch in between your teeth? Any loose teeth? ___________________________	☐Yes	☐No
Do you want to keep your remaining teeth?	☐Yes	☐No
Do you ever hear clicking, popping or discomfort in the jaw joint? Do you brux / grind?	☐Yes	☐No
Have your past experiences in a dental office always been positive?	☐Yes	☐No
Do you smoke or chew tobacco products? Any mouth sores or growths? ________________	☐Yes	☐No
Name of previous dentist (optional) ____	☐Yes	☐No
Date of last full mouth x-rays (16 small films or panoramic) ________________________	☐Yes	☐No

Medical History

Are you under a physician's care now? Why? Who? ___________________________ Phone _____________	☐Yes	☐No
Have you ever been hospitalized or had a major operation? Describe: _______________________________	☐Yes	☐No
Have you ever had a serious injury to your head or neck? Describe: ________________________________	☐Yes	☐No
Are you taking any medications, pills or drugs? Describe: ______________________________________	☐Yes	☐No
Are you on a specific diet? Describe: ____	☐Yes	☐No

Are you allergic to any medications or substances? Please check below:

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex Rubber ___ Other Describe: ______________________

Women – Please check ___Pregnant/Trying to get pregnant ___Nursing ___Taking oral contraceptives

Indicate which of the following you have presently or have had in the past. Check YES or NO for each item.
*If yes to any of the starred conditions, please call prior to your appointment. Pre-medication may be required.

Heart Disease/Attack	☐Yes	☐No	Artificial Joints * (knee, hip, etc)	☐Yes	☐No	Hepatitis A (infections)	☐Yes	☐No
Heart Failure	☐Yes	☐No	Stroke	☐Yes	☐No	Hepatitis B (serum)	☐Yes	☐No
Angina Pectoris	☐Yes	☐No	Kidney Trouble	☐Yes	☐No	Hepatitis C	☐Yes	☐No
Congenital Heart Disease	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Arteriosclerosis	☐Yes	☐No
Venereal Disease	☐Yes	☐No	Ulcers	☐Yes	☐No	Diabetes	☐Yes	☐No
Heart Murmur*	☐Yes	☐No	AIDS or HIV positive	☐Yes	☐No	Glaucoma	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Cortisone Medication	☐Yes	☐No	Herpes/Cold Sores/Fever	☐Yes	☐No
Mitral Valve Prolapse*	☐Yes	☐No	Cosmetic Surgery	☐Yes	☐No	Artificial Heart Valve*	☐Yes	☐No
Emphysema	☐Yes	☐No	Anemia	☐Yes	☐No	Heart Pacemaker*	☐Yes	☐No
Chronic cough	☐Yes	☐No	Heart Surgery*	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Bruise Easily	☐Yes	☐No	Asthma	☐Yes	☐No
Liver Disease	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No
Arthritis	☐Yes	☐No	Hay Fever	☐Yes	☐No	Rheumatism	☐Yes	☐No
Allergies or Hives	☐Yes	☐No	Epilepsy/Seizures	☐Yes	☐No	Fainting or Dizzy Spells	☐Yes	☐No
Sinus Trouble	☐Yes	☐No	Nervousness	☐Yes	☐No	Chemotherapy	☐Yes	☐No
Pain in Jaw Joints	☐Yes	☐No	Radiation Therapy	☐Yes	☐No	Drug Addiction	☐Yes	☐No
Thyroid Problems	☐Yes	☐No	Psychiatric Treatment	☐Yes	☐No			

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if any of the medicines change, I shall inform the dentist and staff at the nearest appointment without failure.

X ________________________________ Date ___________________________ Reviewed By Doctor ______________________________
Patient Signature (Parent or Guardian) Date ________________________ BP ______________

History Review and Significant Findings ____

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), 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 that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, 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 Private 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: X ____

Date: ____

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _________________ Initials: _______________ Reason: _________________________________