PATIENT HISTORY AND INFORMATION

(CONFIDENTIAL INFORMATION IMPORTANT FOR OUR FILES & YOUR HEALTH)

PLEASE PRINT CLEARLY

MR. MRS. MISS MS. DR. OTHER _____ please circle one BIRTH DATE _____

NAME _____PREFERRED NAME _____

last first initial

HOME ADDRESS _____

street city zip

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____ YOUR SS# _____

EMPLOYER _____ PHONE _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____

ADDRESS (IF DIFFERENT) _____ PHONE_____

HOW DID YOU HEAR ABOUT US? _____

HEALTH HISTORY

LAST DENTAL CLEANING & EXAM _____ REASON FOR TODAY'S VISIT _____

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM_____

IN CASE OF EMERGENCY, NOTIFY _____ PHONE _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? PLEASE INDICATE WITH AN X.

__ HEART PROBLEMS/DISEASE	__ M.S./M.D./CEREBRAL PALSY	__ TUBERCULOSIS	__ BLOOD TRANSFUSION (DATES_____)
__ HEART MURMUR	__ EPILEPSY	__ ARTHRITIS	__ CHEMOTHERAPY/RADIATION
__ HIGH BLOOD PRESSURE	__ SLEEP APNEA	__ ASTHMA	__ ARTIFICIAL JOINTS (DATE _____)
__ LOW BLOOD PRESSURE	__ MALIGNANCIES/CANCER	__ THYROID DISEASE	__ ALLERGIES TO _____
__ CIRCULATORY PROBLEMS	__ ALLERGIES TO ANESTHETICS	__ DIABETES	__ SINUS PROBLEMS
__ STROKE	__ JAW/JOINT PAIN	__ ULCER	__ DRUG/ALCOHOL ADDICTION
__ PACEMAKER	__ MEASLES/MUMPS	__ PSYCHIATRIC CARE	__ HEPATITIS (CIRCLE: A B C D E)
__ BLEEDING PROBLEMS	__ COLD SORES	__ LUPUS	__ SEXUALLY TRANSMITTED DISEASE
__ANEMIA	__ RHEUMATIC FEVER	__ POSITIVE HIV/AIDS	__ NERVOUS SYSTEM PROBLEMS
__ ENDOCARDITIS	__ KIDNEY PROBLEMS	__ BRUISE EASILY	__ CORTIZONE MEDICINE
__ TONSILITIS	__ SCARLET FEVER	__ HEMOPHILIA	__ PREGNANT? DUE DATE? _____

EXPLANATION OF ABOVE OR ANYTHING NOT LISTED:

_____

MEDICATIONS: LIST MEDICATIONS YOU ARE TAKING OR HAVE TAKEN WITHIN PAST 30 DAYS (PRESCRIBED OR OVER-THE-COUNTER, I.E. ANTIBIOTICS, BIRTH CONTROL, ASPIRIN, ETC.) _____

_____

ARE YOU CURRENTLY TAKING COUMEDIN, WARFARIN OR ANY BLOOD THINNERS? _____

ARE YOU NOW, OR HAVE YOU EVER, TAKEN ANY DRUGS CALLED BISPHOSPHONATES (I.E. FOSAMAX, ACTONEL, BONIVA, SKELID, ZOMETA, AREDIA, ETC)? _____

DO YOU USE TOBACCO PRODUCTS? _____ TYPE & AMOUNT_____

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE? _____

SIGNATURE _____ DATE _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

NAME OF INSURED _____
SS# OF INSURED _____
DOB OF INSURED _____
RELATIONSHIP TO INSURED _____
EMPLOYER _____
CARRIER _____ GROUP # _____

SECONDARY DENTAL INSURANCE

NAME OF INSURED _____
SS# OF INSURED _____
DOB OF INSURED _____
RELATIONSHIP TO INSURED _____
EMPLOYER _____
CARRIER _____ GROUP # _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

I authorize release of any information relating to my dental claims to the below named dentist. I understand that I am responsible for all of my, or my dependents, costs for dental treatment.
I hereby authorize payment directly to the below named dentist of the insurance benefits otherwise payable to me.

_____
Signature (patient or guardian, if minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature Date

FOR OFFICE USE
WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT IT COULD NOT BE OBTAINED BECAUSE:

__ INDIVIDUAL REFUSED TO SIGN __ COMMUNICATION BARRIERS __ EMERGENCY SITUATION
__ OTHER (Specify) _____

HISTORY UPDATES – FOR OFFICE USE ONLY

_____
_____
_____
_____
_____