PATIENT MEDICAL AND DENTAL HISTORY

Patient's Name: _____ Today's Date: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SSN: _____ Sex: _____ Marital Status: _____

Spouse Name: _____ Spouse Phone Number: _____

Email: _____ Driver's License Number/State: _____

Person to notify in an Emergency/Number: _____

Dental Insurance Information

Name of Insurance: _____ Group Number: _____

Insured's Name: _____ Relationship to Insured: _____

Insured's SSN: _____ Insured's Date of Birth: _____

Employer: _____ Position: _____

Employer Address: _____

Do you have a secondary dental insurance? Y or N If yes: _____

Responsible Party
I am aware that the payment is due at the time of service, and methods of payment include Cash, Check, MasterCard, and Visa.

_____ _____
Signature (patient or parent if minor) Date

Minor/Child Consent
I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

_____ _____
Signature of Parent/Guardian Date

Financial Agreement
We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, “usual and customary” charges, etc..., other than to supply factual information as necessary. You are responsible for the timely payment of your account.
- For patients with insurance, an ESTIMATE will be given of the benefits that the insurance company is expected to pay, and any co-payment is expected at the time services are rendered.
- For patients without insurance, payment is due in full on the day of service. A courtesy will be given only with cash or check. Financial options may be arranged.

_____ _____
Patient/Guardian/Responsible Party Date

Medical History

Do you have, or have you had, any of the following?

___Rheumatic fever/heart disease
___Heart Murmur
___Cardiovascular Disease (heart trouble)
___High Blood Pressure
___Hay Fever
___Sinus trouble
___Asthma
___Diabetes
___Ulcers
___Kidney or Bladder Disease
___Hepatitis A, B, or C
___Liver Disease, Jaundice
___Low Blood Pressure
___Thyroid Condition
___Cancer
___Chemotherapy or Radiation
___Artificial Joints/Implants
___Emphysema
___Tuberculosis
___Anemia/Other Blood Disorder
___Fainting Spells or Seizures (Epilepsy)

Do you have any other condition not listed that may effect your treatment? . . . . Y N
Has there been any change in your general health during the past year?. . . . . Y N
Are you under care other than for routine physicals?. . . . . Y N
Do you bruise easily or have prolonged bleeding?. . . . . Y N
Have you had any serious illness or operation?. . . . . Y N
Describe _____
Have you ever been hospitalized? . . . . . Y N
Reasons:_____
Have you had any chest pains?. . . . . .Y N
Do you smoke? How much?. . . . . .Y N
Do you believe you may be immunosuppressed or HIV positive?. . . . . Y N
Are you taking medication that may affect your immune system?. . . . . Y N
Have you had recurrent mouth sores?. . . . . .Y N
Women: Are you pregnant?. . . . . Y N
Taking Birth Control Pills?. . . . . Y N

Are you allergic to any of the following?

___Antibiotics (Penicillin, Sulfa, Tetracycline)
___Local Anesthetics/Novocaine
___Codeine or other pain killers
___Sedatives
___Aspirin
___Iodine
___Latex
___Other: _____

Are you currently or have you taken any of the following?

___Antibiotics/Sulfa drugs
___Anticoagulants (blood thinners)
___High Blood Pressure Medicines
___Heart Medications (Inderal, Nitroglycerin)
___Steroids (Cortisone, etc...)
___Insulin or diabetic drugs
___Actonel
___Boniva
___Fosamax
___Skelid
___Didronel
___Aredia
___Zometa
___Reclast
___Bonefos

Date of Last :

Full dental examination _____
Full mouth x-ray taken _____
Dental cleaning _____

Please list all medications you are taking: _____

_____

_____

I understand that the information that I have provided is correct to the best of my knowledge, that it is my responsibility to inform the office of any changes in my (or patient's) medical status, and consent to examination by the doctor. I hereby authorize release of any information related to insurance claim and I authorize payment of any insurance benefit to the office. I am aware if I do not give a 24-hour notice, I may be charged a $35 fee.

_____ _____
Signature (patient or parent if minor) Date

Use and Disclosure of Health Information, Acknowledgment of Receipt of Notice of Privacy

I have received a copy of this office's Notice of Privacy Practices. I understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Your office will continue to use my health information in some of these ways: by calling me by my first and last name from your waiting room, by mailing me reminder appointment cards with reason for visit, and by calling to confirm appointments, as described in our Notice of Privacy Practices.

_____ _____
Signature (patient or parent if minor) Date