Welcome

To Our Practice

Please take a few minutes to answer the following questions
so, we can better assist you with your dental needs

* PATIENT INFORMATION

Date _____ Soc. Sec. #_____ Birthdate _____
Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Email _____
Gender: _____ Male _____ Female
Family Status: _____ Married _____ Single _____ Child _____ Other
Employer _____ Business Phone _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ #_____

* PHARMACY INFORMATION

Pharmacy Name: _____ Phone _____
Address_____
City _____ State _____ Zip _____

* PRIMARY INSURANCE

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____ Soc Sec. #_____
Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Email _____
Employer _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber ID #_____

* SECONDARY INSURANCE

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____ Soc Sec. #_____
Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Email _____
Employer _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber ID #_____

* DENTAL HISTORY

Former Dentist _____
City, State _____
Date of Last Dental Visit _____

Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Please check all that apply:

Bad Breath _____
Bleeding Gums _____
Blisters is Mouth _____
Fingernail Biting _____
Grinding Teeth _____
Lip or Cheek Biting _____

Loose teeth _____
Orthodontic Tx _____
Pain Around Ear _____
Periodontal Tx _____
Sensitivity to Cold _____
Sensitivity to Heat _____

Sensitivity to Sweets _____
Sensitivity when Biting _____
Frequent X-Rays _____
Jaw, Head, Neck Injuries _____
Jaw Pain or Clicking _____
Tooth Pain _____

* MEDICAL HISTORY

(MUST BE FILLED OUT COMPLETELY)

Physician's Name _____
Date of Last Visit _____

Are you currently under medical treatment? _____
Have you ever had any serious illness or operations? _____
Are you currently taking any medication? _____
Please describe: _____
_____
Do you smoke? _____
Any alcohol use? _____
Do you wear contact lenses? _____
Are you pregnant or nursing? _____

Have you had any allergic reactions to:
Local Anesthetic (eg. Novocaine) _____
Penicillin or other antibiotic _____
Sulfa Drugs _____
Barbiturates _____
Sedatives _____
Iodine _____
Aspirin _____
Other _____
Taking birth control pills? _____

Please mark "yes" or "no":

	YES	NO		YES	NO		YES	NO
AIDS			Emphysema			Pacemaker		
Anemia			Epilepsy			Psychiatric Care		
Arthritis, Rheumatism			Fainting or Dizziness			Radiation Tx		
Artificial Heart Valves			Glaucoma			Respiratory Disease		
Asthma			Headaches			Rheumatic Fever		
Back Problems			Heart Problems			Scarlet Fever		
Abnormal Bleeding			Hepatitis-Type			Sinus Trouble		
Blood Disease			Herpes			Skin Rash		
Cancer			High Blood Pressure			Stroke		
Chemical Dependency			HIV Positive			Swelling of Feet/Ankles		
Chemotherapy			Jaw Pain			Thyroid Problems		
Chronic Fatigue Syndrome			Kidney Disease			Tonsillitis		
Circulatory Problems			Latex Sensitivity			Tuberculosis		
Congenital Heart Lesions			Liver Disease			Tumor or growth on head or neck		
Cortisone Treatment			Low Blood Pressure			Ulcer		
Persistent Cough			Mitral Valve Prolapse			Venereal Disease		
Diabetes			Nervous Problems					

ASSIGMENT AND RELEASE

I hereby authorize payment to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctor and/ or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

*Signature of Responsible Party_____ Date _____

HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

By signing below, you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below, you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

*Signature _____Date _____