Patient Information

Name: Last:_____ First:_____ MI _____

Preferred Name: _____

Home Address: _____

City:_____State _____ Zip: _____

Home #: _____ Work #: _____

Mobile #: _____

Email:_____

Sex: M / F Birth Date: ___ /___ /_____

SS#:_____

Family Status: Circle one: Single Married Divorced Child

Spouse Name:_____

How did you hear about our office? (circle one)

Another patient	Another dental office	Online search
Facebook	Work	School
Insurance	Sign/Drive by	Other:_____

Responsible Party (if minor)- _____

Relationship to patient- _____

Phone number _____

In case of an emergency, whom should we contact?

Name_____ Relationship _____

Phone number_____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

INSURANCE: You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment!

MISSED APPOINTMENT/CANCELLATION FEE- We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not show up for a scheduled appointment may be charged a fee of at least $25.00 to the account.

I have read the above conditions of treatment, insurance, payment, missed appointment/cancellation fees, and agree to their content.

Signature _____Date _____

Relationship to patient_____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature _____ Date_____

HEALTH HISTORY

Indicate which of the following you have had or currently have by checking yes or no in each box.

Yes	No	Condition	Yes	No	Condition
☐	☐	Pre-med (Amox)	☐	☐	Anemia
☐	☐	Pre-med (Clinda)	☐	☐	Arthritis
☐	☐	Pre-med (other)	☐	☐	Artificial joints
☐	☐	Allergies	☐	☐	Asthma
☐	☐	Allergy- Aspirin	☐	☐	Blood Disease
☐	☐	Allergy- Codeine	☐	☐	Blood Thinners
☐	☐	Allergy- Erythro	☐	☐	Cancer
☐	☐	Allergy- Hay Fever	☐	☐	Diabetes
☐	☐	Allergy- Latex	☐	☐	Dizziness
☐	☐	Allergy- Penicillin	☐	☐	Epilepsy
☐	☐	Allergy- Sulfa	☐	☐	Excessive Bleeding
☐	☐	Allergy- Other	☐	☐	Fainting

☐	☐	Glaucoma	☐	☐	Head Injuries
☐	☐	Heart Disease	☐	☐	Heart Murmur
☐	☐	Heart Stents	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	HIV
☐	☐	Jaundice	☐	☐	Kidney Disease
☐	☐	Liver Disease	☐	☐	Mental Disorders
☐	☐	Nervous disorders	☐	☐	Pacemaker
☐	☐	Pregnancy	☐	☐	Radiation Treatment
☐	☐	Respiratory Problems	☐	☐	Rheumatic Fever
☐	☐	Rheumatism	☐	☐	Sinus Problems
☐	☐	Stomach Problems	☐	☐	Stroke
☐	☐	Tuberculosis	☐	☐	Tumors
☐	☐	Ulcers			
☐	☐	Other			

For any condition or alert with a Yes checked- please explain: _____

Yes	No	
☐	☐	Ever been hospitalized (illness or injury)
☐	☐	Taking medication for weight control
☐	☐	Subject to frequent headaches
☐	☐	Presently being treated for any other illnesses
☐	☐	Taking dietary supplements
☐	☐	A smoker or smoked previously
☐	☐	FEMALE: Taking birth control pills
☐	☐	FEMALE: Pregnant

Please explain anything that is checked Yes above: _____

Do you take antibiotic premedication for your dental visits? If yes, explain:

What is your estimate of your general health?
☐Excellent ☐Good ☐Fair ☐Poor

Name of Physician and phone number: _____

Most recent physical exam and purpose: _____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

_____

List all medications, supplements, and/or vitamins taken in the last two years:

_____

_____

☐ By checking this box, I attest that the information above is correct and it is MY responsibility to let the office know of any changes in my health

Signature _____ DATE _____

DENTAL INFORMATION

How would you rate the condition of your mouth?
☐Excellent ☐Good ☐Fair ☐Poor

Are your fearful of dental treatment? ☐Yes ☐No
If yes, how fearful on a scale of 1-10? _____

Personal History- Check all that apply:
☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Do you have any problems with your jaw (locking, popping, pain, etc)