PATIENT INFO & MEDICAL HISTORY

Please fill out all the following information accurately for us to better care for you. All Information is strictly confidential

WELCOME TO OUR OFFICE! **Date: _____/_____/_____**

Reason for today's dental visit: _____

If you are a new patient, please answer the following:

- *If family members are patients at our practice, list name(s):* _____
- *How did you hear about us?* _____

PATIENT INFO

Patient's Name: _____ Sex: ☐ M ☐ F
(Last / First / MI / Nickname)

DOB: _____/_____/_____ Email: _____ Status: ☐ Child ☐ Single ☐ Married

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Emergency Contact: _____ Relation: _____ Phone #:_____

INSURANCE INFO *Please let us know if you have a secondary insurance*

Insurance Co._____ ID #: _____ Group #: _____ Employer: _____

Responsible Party's Name: _____ Sex: ☐ M ☐ F
(If different from patient) (Last / First / MI)

DOB: _____/_____/_____ Relation to patient: _____ Email: _____

Home #: _____ Cell #: _____ Work #: _____

Patient Medical History:

- Are you apprehensive to dental treatment? **Yes / No**
- Do your gums bleed, feel tender or irritated? **Yes / No**
- Females: are you pregnant? **Yes / No**
- Are you seeing a physician? **Yes / No**
  If Yes, what is the condition being treated? _____
- Are your teeth sensitive to hot, cold, sweets? **Yes / No**
- Are you happy with your smile? **Yes / No**
- If yes, how many weeks/months? _____
- Dr.'s Name/Phone: _____

Check any of the following medical problems which you had or have:

☐ Heart Disease	☐ Blood Disorder	☐ Diabetes	☐ Cancer	☐ ADD/ADHD	☐ Epilepsy/Seizure
☐ Heart Murmur	☐ Prolonged bleeding	☐ Asthma	☐ Arthritis	☐ Nervousness	☐ Developmental Delay
☐ Heart Pacemaker	☐ Anemia	☐ Tuberculosis	☐ Rheumatism	☐ Depression	☐ Venereal Disease
☐ High Blood Pressure	☐ Sickle Cell Disease	☐ Emphysema	☐ Thyroid Disease	☐ Acid Reflux	☐ Hepatitis
☐ Rheumatic Fever	☐ Bone Disease	☐ Glaucoma	☐ Kidney Disorder	☐ Ulcers	☐ HIV+ / AIDS

☐ Other Problems or Details: _____

Check any of the following medications you are allergic to:

☐ Penicillin / Amoxicillin	☐ NSAIDs: Aspirin, Ibuprofen, Aleve	☐ Other Narcotics	☐ Barbiturates / sedatives	☐ Latex
☐ Other Antibiotics	☐ Acetaminophen / Tylenol	☐ Codeine	☐ Sulfa Drugs	☐ Local Anesthetic

☐ Other Allergies or Details: _____

MEDICATIONS: _____

_____

☐ Yes, I currently or have taken **Bisphosphonates** in either pill or IV form for bone issues. (ie. Fosamax, Zoledronate, Boniva, etc.)

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if any medications change, I will inform my dentist at my next appointment.

Signature of Patient/Parent/Guardian: X _____

PATIENT HIPAA FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name: _____

Patient Signature ***(if over 18)***: _____

Print Name of Parent/Guardian***(for minors)***: _____

Signature of Parent/Guardian***(for minors)***: _____

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