

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F email:	Cell Phone ()
Dental Ins. _____ Group _____		Subscriber _____
Secondary Insurance Company _____		Group _____ Subscriber _____

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Cell Phone ()
Responsible Person's Employer	Occupation	Work Phone ()
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address	City	State Zip

How did you hear about our Office?
(check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office? _____

Referred by a friend Yellow Pages Relative Insurance Plan Welcome Wagon

Other _____ TV/Radio Ad Newspaper Ad Direct Mailing Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge _____
Initial **X**

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

X Signature _____ Date _____ Relationship to Patient _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

X Signed _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing.	Y N I have problems eating.
Y N I like my smile.	Y N I have had orthodontics.
Y N I prefer tooth-colored fillings.	Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.	Y N I want my teeth straight.
	Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? please circle Y for yes or N for no.

1. Y N Heart Disease	22. Y N Liver Disease
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice
3. Y N Stroke	24. Y N Hepatitis Type _____
4. Y N Congenital Heart Lesions	25. Y N Diabetes
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)
7. Y N Anemia	28. Y N Herpes
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease
10. Y N Asthma	31. Y N Kidney Disease
11. Y N Hay Fever	32. Y N Tumor or Malignancy
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment
14. Y N Ulcers	35. Y N History of Drug Addiction
15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other	
16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____	
17. Y N I have consumed alcohol within the last 24 hours.	
18. Y N I usually take an antibiotic prior to dental treatment.	
19. Y N Have you ever taken Fen-Phen or Redux?	
20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____	

Doctor Notes Only:

36. Y N AIDS

37. Y N Immune Suppressed Disorder

38. Y N Hearing Loss

39. Y N Fainting Spells

40. Y N Glaucoma

41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?

43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

<p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p>Please list all medications you are currently taking:</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT HIPAA CONSENT 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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company).
- 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.

Signed this _____ day of _____ 20_____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____