



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
<input type="checkbox"/>	<input type="checkbox"/>	Pre-med (Amox)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Pre-med (Clinda)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Pre-med (other)	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Erythro	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Latex	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Other	<input type="checkbox"/>	<input type="checkbox"/>	Fainting

- | | | | | | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Head Injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Stents | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | | | |

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

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Ever been hospitalized (illness or injury) |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking medication for weight control |
| <input type="checkbox"/> | <input type="checkbox"/> | Subject to frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Presently being treated for any other illnesses |
| <input type="checkbox"/> | <input type="checkbox"/> | Taking dietary supplements |
| <input type="checkbox"/> | <input type="checkbox"/> | A smoker or smoked previously |
| <input type="checkbox"/> | <input type="checkbox"/> | FEMALE: Taking birth control pills |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 you 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)