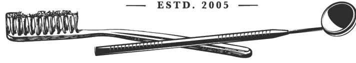

ABOUT YOU

Today's Date: ______________

Name: ______________________________
LAST FIRST MI MR MRS MS DR

I prefer to be called: ______________

SS #: ______________

Birthdate: __________ Age: ____ ☐ Male ☐ Female ☐ Gender Neutral

Home Address: ______________________________
APT/CONDO #:

____
CITY STATE ZIP

Cell #: ______________

E-mail Address: ______________

How do you prefer to be contacted? ☐ E-Mail ☐ Phone ☐ Text

Employer: ______________

Occupation: ______________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Other family members seen by us: ______________

Previous / Present Dentist: ______________
(Please Circle)

Last Visit Date: ______________

How did you find out about us? ☐ Friend ☐ Google ☐ ZocDoc ☐ Yelp ☐ Facebook ☐ Other

Whom may we Thank for referring you? ______________

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate: __________ Insured's ID #: ______________

Insured's Employer: ______________

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate: __________ Insured's ID #: ______________

Insured's Employer: ______________

SPOUSE INFORMATION

His / Her Name: ______________

Employer: ______________

SS #: ______________ Birthdate: ______________

Person Responsible for Account: ______________

Cell: ______________ Employer: ______________

Billing Address: ______________

Relation: ______________ SS #: ______________

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: ______________ Relation: ______________

Wk #: ______________ Cell #: ______________

CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________

Phone #: ______________ Date of last visit: __________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: ______________________

____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Week #: ________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer /Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV^+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Please list any other drugs/materials that you are allergic to:

____

____

DENTAL HISTORY

Why have you come to the dentist today?

____

____

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? a day do you brush?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______________________ Date __________

Signature

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

____

Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

INTERNAL USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ________ Date: ______________

Doctor's Comments: ______________________

____

NOTICE OF PRIVACY POLICIES

Health Insurance Portability Accountability Act (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

Name: ______________________________ Phone: ______________________________

Address: ____

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.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS

You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

____
Signature

FOR OFFICE USE:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Specify) ______________________________