Welcome To Our Practice

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Patient Information (confidential)

Today's date:_____

Name:_____Birthdate:_____Soc. Sec. #:_____

Address:_____City:_____State:_____Zip:_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home phone:_____Cell phone:_____Work phone:_____

Patient or Parent's Employer:_____ Address:_____

Spouse or Parent's Name:_____Employer:_____

How did you hear about us?_____

Person to Contact in Case of Emergency:_____Phone:_____

Responsible Party

Name of Person Responsible for this Account:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Driver's License #:_____Birthdate:_____Email Address:_____

Employer:_____Work Phone:_____

Is this Person Currently a Patient in Our Office:_____

Insurance Information

Name of Insured:_____Relationship to Patient:_____

Birthdate:_____Soc. Sec. #_____Member ID#_____

Name of Employer:_____Insurance Company:_____

Insurance Company Phone:_____Group No:_____

Secondary Insurance Information

*Name of Insured:*_____*Relationship to Patient:*_____

*Birthdate:*_____*Soc. Sec. #*_____*Member ID#*_____

*Name of Employer:*_____*Insurance Company:*_____

*Insurance Company Phone:*_____*Group No:*_____

Notice of Privacy Practices

I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance, and in communicating with other healthcare professionals in the course of my treatment. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support personnel, billing personnel, answering services and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.
I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance activities, insurance claims and health care operations. This office retains the right to revise the privacy policy.

_____ _____
Signature of Patient or Legal Guardian **Date**

Although we primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive or medications we prescribe. Thank you for answering the following questions.

Date of last dental examination: _____Date of last medical examination: _____

Are you allergic to any of the following: ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine**
☐ **Local Anesthetics** ☐ **Latex** ☐ **Other** **If yes, please explain: _____**

Do you have any of the following conditions:

YES	*NO*	
☐	☐	Anemia
☐	☐	Diabetes Type: _____
☐	☐	Epilepsy If yes, date of last seizure: _____
☐	☐	Hepatitis If yes, what type: _____
☐	☐	Artificial Implants, Heart Stents, Joint Replacements: If yes, what type: _____ Does condition require pre-medication: _____Are you premedicated today: _____
☐	☐	Abnormal Heart Condition If yes, explain: _____
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Any type of Mental Illness or Physical Condition? If yes, what type: _____ _____
☐	☐	Are you pregnant? If yes, how many months: _ _____
☐	☐	Abnormal Bleeding from a Cut? (Hemophilia) _____
☐	☐	Rheumatic Fever (even as a child)
☐	☐	Cancer If yes, when and what type: _____
☐	☐	HIV Positive
☐	☐	Are you currently under the care of a physician? Physician Name: _____ Physician Phone Number: _____
☐	☐	Are you currently taking any medication on a daily basis? (**including Blood Thinners or daily Aspirin)** Please list or use additional paper if necessary: _____ _____ _____
☐	☐	Have you ever been hospitalized or had a major operation? If yes, please explain: _____ _____

By signing below, I acknowledge that I am over the age of 18 and/or I am the legal parent or guardian.

_____ _____
Signature of PATIENT, PARENT or Guardian **Please Print Name**

Date: _____