## Patient Information

Patient name: _____ Date of birth: ____/____/_____
Last First Middle Initial

Age: _____ Sex: Male / Female What name do you wish to be addressed? _____

**Marital status:** Married / Single / Child / Widowed

Home address: _____

City: _____ State: _____ Zip: _____ **Home #:** _____

**Cell #**: _____ **E-mail**: _____ **SS #:** _____-_____-_____

Driver's license #: _____

***Emergency contact***: _____ ***Phone #***: _____
Last First

Referred to us by / how did you hear about us: _____

Are you currently under a physician's care? NO / YES Reason: _____

Name of your medical doctor: _____ Date of last visit: ___/___/____

Name of previous dentist: _____ Date of last visit: ___/___/____

## Dental Health History

Reason for seeking dental care at this time: _____

Are you apprehensive about dental treatment: No Somewhat Yes

**Do you have any of the following? Mark all that applies.**

| | | | |
|---|---|---|---|
| ☐ Aching or sensitive teeth | ☐ Broken tooth | ☐ Dry mouth | ☐ Lumps in mouth |
| ☐ Areas of food traps | ☐ Chewing on one side | ☐ Grinding or clenching | ☐ Missing teeth |
| ☐ Bad breath | ☐ Clicking or popping in jaw | ☐ Gum infection | ☐ Sensitivity |
| ☐ Bleeding gums | ☐ Cold sores | ☐ Jaw pain or tiredness | ☐ Swelling in mouth |
| ☐ Braces | ☐ Difficulty opening wide | ☐ Loose teeth | ☐ Swollen glands |
| ☐ Broken filling | ☐ Other: _____ | | |

**Do you snore or have been told that you snore?** NO / YES

**If you could change your smile, what would you change? Mark all that applies.**

| | | |
|---|---|---|
| ☐ Remove silver fillings | ☐ Replace missing teeth | ☐ Straighten teeth |
| ☐ Close gaps between teeth | ☐ Change shape of teeth | ☐ Whitening |
| ☐ Other: _____ | | |

## For Women Only

Are you pregnant? NO / YES Expected delivery date: _____
Are you nursing? NO / YES Are you taking birth controls? NO / YES

**Patient / Guardian Signature:** _____ **Date:** ____/____/_____

## Medical History

**Do you have any of the following? Mark all that applies:**

| | | | |
|---|---|---|---|
| ☐ Abnormal bleeding | ☐ Cold sores / Herpes | ☐ Hepatitis _____ | ☐ Rheumatic fever |
| ☐ AIDS / HIV | ☐ Congenital heart disorder | ☐ High / Low blood pressure | ☐ Scarlet fever |
| ☐ Alzheimer's | ☐ Diabetes | ☐ High cholesterol | ☐ Shingles |
| ☐ Anemia | ☐ Emphysema | ☐ Hives / Rash | ☐ Shortness of breath |
| ☐ Arthritis | ☐ Epilepsy / Seizures | ☐ Hypoglycemia | ☐ Sinus trouble |
| ☐ Artificial heart valve | ☐ Excessive thirst | ☐ Inner ear disorders | ☐ Stroke |
| ☐ Artificial joints | ☐ Fainting or dizzy spells | ☐ Jaundice | ☐ Surgical prosthesis |
| ☐ Asthma | ☐ Frequent headaches | ☐ Leukemia | ☐ Taking heart medications |
| ☐ Blood disease | ☐ Glaucoma | ☐ Liver disease | ☐ Thyroid disease |
| ☐ Blood thinners | ☐ Hay fever | ☐ Lung problems | ☐ Tuberculosis |
| ☐ Bruise easily | ☐ Heart attack | ☐ Osteoporosis | ☐ Ulcers / Stomach problems |
| ☐ Cancer | ☐ Heart murmur | ☐ Pacemaker | ☐ Venereal disease |
| ☐ Chemotherapy | ☐ Heart valve problems | ☐ Persistent cough | ☐ Vertigo |
| ☐ Chest pain | ☐ Hemophilia | ☐ Psychiatric care | |

**Do you have any disease, condition, or problem not listed previously that you feel we should know about?**

If so, please describe: _____

_____

**List all medications and dietary supplements you are taking including the dosage:** _____

_____

_____

**Are you required to pre-medicate before a dental appointment?** NO / YES

## Allergies

**Mark all medications or health care related substances to which you have experienced an adverse reaction.**

☐ Penicillin ☐ Sulfa drugs ☐ Latex ☐ Epinephrine ☐ Codeine ☐ Local anesthetics
☐ None ☐ Other: _____

## Privacy Policy

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. A copy of our Privacy Policy is available upon request.
**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**I, (please print name)**_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Patient / Guardian Signature:** _____ **Date:** ____/____/_____

## Dental Insurance Information and Insurance Agreement

**Primary Dental insurance**: _____Phone #: _____

Subscriber's name: _____ Date of birth: ____/____/_____

Subscriber's SS #: _____-_____-_____

ID#: _____ Group #: _____

**Secondary Dental insurance**: _____ Phone #: _____

Subscriber's name: _____ Date of birth: ____/____/_____

Subscriber's SS #: _____-_____-_____

ID #:_____ Group #: _____

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

**Patient / Guardian Signature: _____ Date: ____/____/_____**

## Consent for Treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs.

I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

I understand that the proposed treatment may change for unforeseen reasons and that I am responsible for the work done.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. I understand that payment by my insurance is not guaranteed and fees collected at the beginning of services are estimated.

I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

**Patient / Guardian Signature: _____ Date: ____/____/_____**