CONFIDENTIAL PATIENT INFORMATION

Patient: Name _____/Preferred_____ Today's Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H: (____)_____ W: (____)_____ Cell: (____)_____

E-mail: _____ Would you prefer appointment reminders via e-mail? Yes: ❑ No: ❑

Place of Employment: _____ Occupation: _____

Date of Birth: _____ SS#: _____ Female ❑ Male ❑

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other Referred by: _____

Emergency Contact: _____

Spouse/Parent Name: _____

Address (if different from above): _____

Place of Employment: _____ Occupation: _____

Dental Insurance Information:

Primary Carrier: _____

Mailing Address: _____ Phone: _____

Employee: _____ SS#: _____ Date of Birth: ____/____/____

Group #: _____ Carrier Phone #: _____

Secondary Carrier: _____

Mailing Address: _____ Phone: _____

Employee: _____ SS#: _____ Date of Birth: ____/____/____

Group #: _____ Carrier Phone #: _____

Responsible Party (include address and phone #, if different from above): _____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have seen a copy of this office's Notice of Privacy practices.
Please print name above

Signature: _____ Date: ____/____/____

Dental Health: Please check one: _____ Excellent _____ Good _____ Fair _____ Poor

How long has it been since your last dental visit? _____

Is there anything you would like to change about your smile/teeth? Yes ❑ No ❑

Do you use tobacco products? Yes ❑ No ❑ If yes, what kind? _____

Medical Health: Please check one: _____ Excellent _____ Good _____ Fair _____ Poor

Physician's Name: _____ Phone #: _____

Date of last complete physical: _____/_____/_____ Are you under a physician's care now? Yes ❑ No ❑

If yes, for what reason? _____

Do you have fainting spells? Yes ❑ No ❑ Are you subject to prolonged bleeding? Yes ❑ No ❑

Are you on blood thinning agents (such as Coumadin, aspirin, fish oil, etc.)? Yes ❑ No ❑

Are you allergic to any of the following? _____Penicillin _____Codeine _____Local Anesthetics _____Latex

Any other allergies (including seasonal)? Yes ❑ No ❑ If yes, what? _____

Please list all prescription medications, herbal supplements and over-the-counter meds you are taking: _____

_____

_____

_____

Please Circle if you have or have had any of the following:

Allergies	Chemotherapy	Hepatitis A	Radiation	Chest pain/Angina
Alzheimer's	Hypoglycemia	Hepatitis B	Recent Weight Lost	Congenital Heart Defect
Anemia	Kidney Trouble	Hepatitis C	Rheumatic fever	Diabetes
Arthritis	Glaucoma	High Blood Pressure	Shortness of Breath	Emphysema
Artificial Heart Valve	Hay Fever	HIV Positive	Sinus Trouble	Epilepsy/Seizures
Artificial Joints	Heart Murmur	Ulcers	Stroke	Frequent Cough
Asthma	Heart Pacemaker	Mitral Valve Prolapse	Swelling of ___ Feet,	Liver Disease
Auto Immune	Heart Surgery	Bacterial Endocarditis	__Ankles, __Hands	Low Blood Pressure
Blood Disease	Heart Trouble	Prostate Problems	Thyroid Disease	Lung Disease
Cancer	Hemophilia	Psychiatric Care	Tuberculosis	High Cholesterol

Have you ever had any other serious illness not listed above? Yes ❑ No ❑ If yes, please describe: _____

_____

_____

_____

Females: Do you take any hormone therapy drugs? Yes ❑ No ❑
Do you take birth control pills, patches, injections? Yes ❑ No ❑
Are you pregnant? Yes ❑ No ❑ If yes, how far along? _____

Patient or Responsible Party's Signature: _____

• By signing as the responsible party you are assuming the responsibility of this account. This includes responsibility for any person not covered by insurance. Please also be aware that we have a late cancel/no show fee of $40.00 per unit of time reserved.

While insurance is meant to be an aid, it in no way dictates the treatment we may recommend for you. Our treatment plans are based upon our diagnoses and are not meant to follow or be dictated by your benefits. Payment may be denied for certain procedures even though the patient and the dentist agree that the submitted treatment plan is in the patient's best interest. If the proposed treatment is provided, the patient must understand that it is his/her sole responsibility. It is your responsibility to have your dental insurance information to our office at the first appointment or at the first indication that your insurance has changed.