TURTLE CREEK DENTAL
ASSOCIATES

# PATIENT INFORMATION FORM

## PATIENT INFORMATION

Chart# ______________________
FOR OFFICE USE ONLY

Patient Name*: ______________________ ______________________ ______ ______________________
Last First Mi Preferred Name

Title: ____________ Gender*: Male Female Family Status*: Married Single Child Other
Mr/Ms/Mrs/Dr/etc

Birth Date*: ____________ Drivers License #: ______________ Email Address: ______________________

Phone: ____________ ____________ ______ ______________ Social Security #: ______________
Mobile Work Ext. Home

How do you prefer to receive your appointment confirmations? Text Email Phone

Address*: ______________________________________________

______________________ ______________________ ____________
City State Zip Code

How did you hear about us?: Doctor referral Friend/Family Found on Google Found on Healthgrades/Yelp/Other

Name of person, office, or other source referring you to our practice: ______________________

## SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for*: The patient's spouse The person responsible for payment Neither-not applicable

Patient Name*:

Title: Gender*: Male Female Family Status*: Married Single Child Other

Birth Date*: ____________ Prov Visit: ______________ Email Address: ______________________

Phone: ____________ ____________ ______ ______________ Best time to call: ______________
Mobile Work Ext. Home

Address*: ______________________________________________

______________________ ______________________ ____________
City State Zip Code

## EMPLOYMENT INFORMATION

The following relates to: The patient The person responsible for payment

Employer Name: ______________________________ Phone: ______________

Address: ______________________________________________

______________________ ______________________ ____________
City State Zip Code

# PATIENT INFORMATION FORM

## PRIMARY INSURANCE INFORMATION

Name of Insured: ____________________

Insured Birth Date: ____________ ID# ____________ Group# ____________

Insured's Address: ____________________

City ____________ State ____________ Zip Code ____________

Insured's Employer Name: ____________________

Employer Address: ____________________

City ____________ State ____________ Zip Code ____________

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: ____________________

Insurance Address: ____________________

City ____________ State ____________ Zip Code ____________

## SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: ____________________

Insured Birth Date: ____________ ID# ____________ Group# ____________

Insured's Address: ____________________

City ____________ State ____________ Zip Code ____________

Insured's Employer Name: ____________________

Employer Address: ____________________

City ____________ State ____________ Zip Code ____________

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: ____________________

Insurance Address: ____________________

City ____________ State ____________ Zip Code ____________

**Consent for Services**

*I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

* I understand that all charges are due at time of service. If I have dental insurance, I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: ____________________

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# MEDICAL & DENTAL HISTORY FORM

Patient Name*: ______________ ______________ ____ ______________
Last | First | Mi | Preferred Name

Within the past year, have there been any changes in your general health? Yes No

If Yes, please explain: ______________

What is the date of your last medical exam*?: ______________

Please list your Primary Care Physician's name, address, & phone number*: ______________
Name

______________

______________ ______________ ______________
City | State | Zip Code

Have you been hospitalized within the last 5 years due to a surgery or illness*? Yes No

If Yes, please explain: ______________

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No Date: ______________

Does your physician recommend that you take antibiotics prior to dental treatment*?: Yes No I don't know

Are you taking or scheduled to begin taking either of the medications, Fosemax or Actonel for osteoporosis or Paget's disease*?: Yes No

**Please List All Medications:** (prescription and non-prescription):

______________

Please list pharmacy name and phone #: ______________ ______________
Name | Phone

Have you ever had any complications following dental treatment*?: Yes No

If Yes, please explain: ______________

Do you use tobacco (smoking or chewing)?: Yes No Woman Only: Are you pregnant*?: Yes No

If Yes, when is the due date?: ______________

**Please check any of the following that apply to you:**

- * Pre - Med - Amox
- *Pre - Med - Clind
- *Pre - Med - Other
- Allergies
- Allergy - Aspirin
- Allergy - Codeine
- Allergy - Erythro
- Allergy - Hay Fever
- Allergy - Latex
- Allergy - Other
- Allergy - Penicillin
- Allergy - Sulfa
- Anemia
- Anesthetic – no vaso
- Arthritis
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Crohn's
- Diabetes
- Dizziness
- Epilepsy
- Excesive Bleeding
- Fainting
- Glaucoma
- Head Injuries
- Headaches
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- HIV
- Jaundice
- Kidney Disease
- Liver Disease
- Lupus
- Mental Disorders
- MVP
- Nervous Disorders
- Other
- Pacemaker
- Pregnancy
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Shingles
- Sinus Problems
- Stomach Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Tumors
- Ulcers
- Venerreal Disease

# MEDICAL & DENTAL HISTORY FORM

Are you in any discomfort now*?: Yes No

**Please check any of the following problems that apply:**

Discomfort, clicking or popping in jaw
Red, swollen or bleeding gums
Sensitive tooth, teeth or gums
Blisters/Sores in or around the mouth
Lost/Broken Filling(s)
Teeth grinding/clenching
Ringing in ears
Broken/Chipped Tooth
Stained teeth
Locking Jaw
Bad Breath
Other

When was your last dental visit*?: ______________________

Prior Dentist's name, address, & phone number: ______________________
Name

______________________

City ______ State ______ Zip Code ______

Phone Number ______

How frequently do you brush your teeth?

3(+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

1(+) a day 2-6 weekly 1-6 monthly Seldom Never

If you could change anything about your mouth, teeth, or smile, what would it be?:

______________________

*To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

**Authorization**

* I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Response Date: ______________________

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# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that this facility reserves the right to change their Notice of Privacy Practices and that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

I would like to authorize the release of my medical/dental information to the following individuals:

______________________________

I authorize the doctor and staff to communicate with me via:

Text Message

Email

Voicemail

I understand that these communications may contain medical/dental information.

Date: ______________________________

Signature of Individual or Legal Representative: ______________________________

Printed Name of Individual or Legal Representative: ______________________________