

## PATIENT INFORMATION

Chart# \_\_\_\_\_

FOR OFFICE USE ONLY

Patient Name\*: \_\_\_\_\_  
Last First Mi Preferred NameTitle: \_\_\_\_\_ 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: \_\_\_\_\_

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

# MEDICAL & DENTAL HISTORY FORM

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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?:

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\*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: \_\_\_\_\_

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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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:

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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: \_\_\_\_\_