

Patient Name: Date of birth:

Address: Home phone:

 Work phone:

Email: Cell phone:

Preferred contact method: Home phone Work phone Cell phone Email

SSN: Occupation:

Spouse’s name: Occupation:

Person responsible for account: Date of birth:

 SSN:

**Primary Dental Insurance:**

Employer: Address:

Insurance company: Address:

Group Number:

Member ID number (if applicable):

**Secondary Dental Insurance:**

Employer: Address:

Insurance company: Address:

Group Number:

Member ID number (if applicable):

How did you come to learn about our office?

**Authorization, Release, and Agreement to pay for services rendered (please sign all three)**

I agree to be responsible for payment of all services rendered on behalf of myself and my dependents. I authorize the dentist to release any information to third party payors, collection agencies, and/or other health practitioners as needed. This may include the diagnosis and records of any examination or treatment rendered.

x: Date:

I authorize and hereby request my insurance company to pay, directly to the dentist, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

x: Date:

Federal regulations require that we ask you to sign this acknowledgement of receipt of privacy practices. Good faith and reasonable effort will be made to allow for timely delivery of necessary healthcare while safeguarding patient privacy and complying with federal and state regulations. You have specific rights concerning your personal health information. The notice is posted in our office and you may request a printed copy.

You may refuse to sign this acknowledgement.

x: Date:

 For Office Use Only

 Individual refused to sign

 Communication Barriers prohibited obtaining acknowledgement

 Emergency situation prohibited us from obtaining acknowledgement

 Other (specify)

**Health Information**

Please check which of the following you have had or have at the present.

\_\_Heart Disease Heart Attack \_\_Asthma

\_\_Heart Valve Replacement \_\_HIV/AIDS \_\_Latex Allergy

\_\_Rheumatic Fever \_\_Hepatitis Thyroid Issues

\_\_High Blood Pressure \_\_Liver Disease \_\_Diabetes

\_\_Pacemaker \_\_Tuberculosis \_\_Radiation Treatments

\_\_Stroke \_\_Dizziness/Fainting \_\_Osteoporosis

\_\_Epilepsy \_\_Joint Replacement \_\_Cancer

Please list any other health concerns you think we should be aware of.

Please list any medications you are allergic to or have had adverse reactions to.

Do you currently use any type of tobacco products? Yes No

If yes, what type?

Do you vape? Yes No

For women: Please tell us if you are pregnant. Yes No

Have you ever taken Fosamax or any other bisphosphonate drug? Yes No

Please list all medications you are currently taking and reason for taking.

**Dental History**

Please list the name of your previous dentist and the date of your most recent exam if other than this office.

Do you have any immediate dental concerns? Yes No

If so, please tell us about them here:

Is there anything about the appearance of your teeth you would like to change?

Do you have a history of gum disease? Yes No

How do you feel about dental treatment?

\_\_\_no problem \_\_\_worry about it \_\_\_very fearful

Have you had any serious problems associated with dental treatment? Yes No

Have you had any adverse reactions to dental anesthetic? Yes No

If so, which one?

Have you had a history of difficulty getting numb? Yes No