PATIENT INFORMATION

Name:_____ Gender:_____ Date of Birth_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married If minor proceed to section 2

SS#:_____ Email:_____Employer:_____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Address:_____ City:_____State:_____ Zip:_____

Person to contact in an emergency: _____Phone number: _____

Whom may we thank for referring you to us? _____

THIS SECTION FOR MINORS ONLY

Father or Guardian
Name:_____

Address:_____

City:_____ State:_____

Home Phone:_____

Employer:_____

Work Phone:_____

Mother:
Name:_____

Address:_____

City:_____ State:_____

Home Phone:_____

Employer:_____

Work Phone:_____

DENTAL INSURANCE INFORMATION – Must be filled out completely

Name of Policy Holder:_____ Relationship to patient:_____

Date of Birth:_____ Social Security # _____-_____-_____

Employer of Policy Holder:_____ Group Policy #_____

Name of Insurance Company:_____ Policy Holder ID #_____

Do you have secondary dental insurance? ☐ No ☐ Yes If yes, proceed.

Name of Policy Holder:_____ Relationship to patient:_____

Date of Birth:_____ Social Security # _____-_____-_____

Employer of Policy Holder:_____ Group Policy #_____

Name of Insurance Company:_____ Policy Holder ID #_____

Patient Name:_____

Have your ever had a bad experience or feel nervous in a dental office?	Yes	No
Have you been hospitalized within the past two years?	Yes	No
Have you ever had excessive bleeding requiring special treatment?	Yes	No
Are there any sores or any growths in your mouth now?	Yes	No
Have you ever seen a (gum specialist) periodontist?	Yes	No

Please indicate with a check mark any jaw related problems:
Clicking ☐ Pain in or around your ears ☐ Difficulty opening or closing ☐ TMJ/TMD ☐
Difficulty chewing ☐ Habitual Clenching or Grinding ☐ History of trauma to your jaw ☐

Please indicate with a check mark if you are currently experiencing:
Swelling in your mouth ☐ Bad taste in your mouth ☐ Loose tooth or teeth ☐
Gum Problems ☐ Other: _____

Please indicate any sensitivity to:
Hot ☐ Cold ☐ Sweet ☐ Biting/Pressure ☐

Women: Pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

Allergies:

Aspirin	Yes	No	Local Anesthetics	Yes	No
Barbiturates	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Sulfa	Yes	No
Iodine	Yes	No	Metals	Yes	No
Latex	Yes	No	Other: _____		

Do you have/previously had, currently taking/previously taken medication for any of the following:

Chest Pain	Y N	Shortness of Breath	Y N	Hives or Skin Rash	Y N
Heart Problems	Y N	Emphysema	Y N	Kidney Trouble	Y N
Heart Surgery	Y N	Cold Sores	Y N	Hemophilia	Y N
Diabetes	Y N	Oral Herpes	Y N	Angina Pectoris	Y N
Liver Disease/Jaundice	Y N	Lung Disease	Y N	Glaucoma	Y N
High Blood Pressure	Y N	Fainting/Dizzy Spells	Y N	Steroid Treatment	Y N
Hepatitis A B C Other	Y N	Arthritis	Y N	Epilepsy or Seizures	Y N
Any type of Implant	Y N	Anemia	Y N	Use of Fen Phen	Y N
Any type of Transplant	Y N	Persistent Cough	Y N	Tuberculosis (TB)	Y N
Bisphosphonate Treatment	Y N	Asthma	Y N	HIV+	Y N
Use of Tobacco Products	Y N	Drug Addiction	Y N	Bruise Easily	Y N
Sickle Cell Disease	Y N	Alcoholism	Y N	Dentures or Partials	Y N
Psychiatric Treatment	Y N	Ulcers	Y N	Sinus Trouble	Y N
Blood Transfusion	Y N	Thyroid Disease	Y N	Artificial Joint	Y N
Radiation/Chemo Therapy	Y N	Eating Disorde	Y N		

Please list medications you are currently taking:

_____

I certify I have read and understand the above information and the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Parent Signature: _____ Date:_____

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- **Your protected health information is accessed and used for healthcare related purposes only.**
- **Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.**
- **Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.**

Certain Circumstances

Your protected health information can be discussed without your written authorization in certain limited circumstances,

- **Medical emergencies**
- **In situations required by law**
- **Individuals involved in your care**
- **When requested by public health agency**
- **When requested by a law enforcement agency**

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patients Rights

- **You have the right to request in writing to inspect and/or receive a copy of your health information.***
- **You have the right to request an alternative means or location to receive communications regarding your health information.***
- **You have the right to request in writing to amend, correct or delete any recorded health information within our possession.***
- **You have the right to request in writing to restrict some of the uses and disclosures of your health information.***
- **You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.***

***Conditions and limitations may apply; obtain additional information from the front desk.**

Signature:_____ **Date:**_____

Office Policies
Please take the time to acknowledge our Office Policies
Effective April 2015

Cancellations: Short Notice Cancellations of less than 24 hours may result in a **$50** cancellation fee. This applies to no-call, no show appointments as well as short notice cancellations. Making or breaking appointments in a timely manner is your responsibility and these charges will not be covered by insurance

If there are three consecutive missed appointments in one family, we will no longer be able to reserve time for you. You may however come in on a "Walk-In Basis". This means that if we can, we will make every effort to fit you in but it is not a guarantee depending on your schedule. Patients with appointments take priority.

Our office will call you to remind you of appointments the day before the scheduled time. Would you like to receive test messages from our office as well? ☐ Yes ☐ No

Payments and co-pays: Payments and co-pays are required on the Day of Service. We do accept Care Credit as a way of financing your important dental care. Please ask us for more information if you need this financing.

Insurance Payments: We will make every effort to provide you with the most current and up to date insurance benefits, however this is not a guarantee of payment from your insurance company. Any balances not paid by insurance are your responsibility.

Please take time to carefully review the following and agree to the terms listed:

_____ (initials) I understand that the services provided to myself or my minor child are not always covered by insurance or my insurance carrier may pay less than the actual bill for rendered services. I agree to make full payment for these services. This may include but is not limited to: copayments, recommended fluoride treatments, necessary diagnostic radiographs and procedures done elsewhere that I have not given notice of.

_____ (initials) I acknowledge that I have received and read a copy of Notice of Privacy Practices Sheet with this form.

_____ (initials) I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my minor child during the period of such dental care to third party payors and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist the benefits otherwise payable to me.

Patient Name: _____

Signature_____Date:_____