Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Ph. _____

City _____ State _____ Zip _____

Sex ❒ M ❒ F Age _____ Birthdate _____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Domestic Partner

Patient Employed by _____ Occupation _____

Email _____ Bus. Ph. _____ Cell. Ph. _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Bus. Address _____ Bus. Ph. _____ Cell. Ph. _____

Insurance Company _____ Subscriber ID# _____ Group # _____

Secondary Insurance

Is patient covered by additional insurance? ❒ Yes ❒ No

Name of Insured _____ _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Bus. Ph. _____

Insurance Company _____ SS# or Subscriber ID# _____ Group # _____

Method of Payment

Which of the following methods of payment will you be using? (Fees must be paid in full at the completion of treatment.)

Method of Payment: ❒ Cash ❒ Check ❒ VISA ❒ MC ❒ Discover ❒ Care Credit

All information written is true and complete. SIGNATURE: _____ DATE: _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS: _____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

PLEASE PRINT NAME: _____ SIGNATURE: _____ DATE: _____

**You may refuse to sign this acknowledgement ❒ Patient refused to sign HIPAA _____

Updates (date & initial) _____ _____ _____ _____ _____

MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. Has there been any change in your general health within the past year?	❑	❑
Please specify _____		
2. Are you under the care of a physician for a current problem?	❑	❑
Reason _____		
3. Have you been hospitalized within the past five years?	❑	❑
Reason _____		
4. Are you currently taking any medications or drugs?	❑	❑
Please list _____		
5. Have you received therapy for alcoholism or drug addiction during the past five years?	❑	❑
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to **LATEX**, anesthetics, antibiotics, or other medications?	❑	❑
Please specify _____		
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	❑	❑
8. Have you ever required a blood transfusion?	❑	❑
Please explain _____		
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	❑	❑
10. Have you ever been tested for HIV infection (AIDS)?	❑	❑
result of test: Date _____ ❑ Positive ❑ Negative		
11. Date of last physical exam _____		

12. Do you have or have you had any of the following (please check):

- ❑ High blood pressure
- ❑ Heart murmur of prolapsed valve (MVP)
- ❑ Joint prosthesis (hip, knee, etc.)
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Congenital heart disease
- ❑ Do you have a pacemaker or a Cochlear implant?
- ❑ Cardiovascular disease: heart attack, stroke, by-pass
- ❑ Are you taking any blood thinners?
- ❑ Prosthetic heart valve
- ❑ Blood disorder (e.g., anemia)
- ❑ STD
- ❑ Asthma
- ❑ Temporomandibular joint problems (TMJ)
- ❑ Tobacco use
- ❑ Sinus trouble
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Stomach ulcers, colitis
- ❑ Hepatitis, jaundice, liver disease
- ❑ Kidney problems
- ❑ Psychiatric treatment
- ❑ Fainting spells or seizures
- ❑ Epilepsy
- ❑ Cancer
- ❑ Are you currently, or have you taken medicines for Osteoporosis?
- ❑ Delay in healing

13. Do you have any disease, condition, or problem not listed above?	❑	❑
Please specify _____		
14. Are you required to take premeds prior to dental treatment?	❑	❑

Women:

15. Are you pregnant?	❑	❑
16. Are you nursing?	❑	❑
17. Do you take birth control pills?	❑	❑
If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.		

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Date _____ Signature of Patient* _____

*All signatures must be by parent or guardian if patient is under the age of 18.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received and reviewed a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

HIPAA RELEASE FORM

Authorization to Release Records

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care and account information.

Name	Relation	Phone Number
Name	Relation	Phone Number