Patient Information

Name _____ Cell Phone:
Last First Initial

Address _____ Home Tel:

City State Zip

Sex ☐ M ☐ F Age ____ Birthdate _____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced

Email: _____ Occupation _____

Emergency Contact Telephone

Preferred Pharmacy _____ Pharmacy Telephone

Primary Insurance

Primary Subscriber _____
Last Name First Name Initial

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

Address (if different from patient's) _____ Phone

City _____ State _____ Zip _____

Employer _____ Occupation _____

Bus. Address _____ Bus. Ph. _____

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

Secondary Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Primary Subscriber _____
First Name Last Name Initial

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

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

City _____ State _____ Zip _____

Employer _____ Occupation _____

Bus. Address _____ Bus. Ph. _____

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

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:

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

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? ..... Please specify: _____	☐	☐
3. Have you been hospitalized within the past five years? ..... Please specify:	☐	☐
4. Are you currently taking any medications or drugs?	☐	☐
5. Please list: _____ _____		
6. Have you received therapy for alcoholism or drug addiction during the past five years?	☐	☐
7. 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. Are you currently, or have you taken medicine for Osteoporosis? ..... Name of medication and dosage: _____ Frequency: _____ Date Taken _____		

11. 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)
- ☐ Asthma
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Tobacco use
- ☐ HIV/AIDS
- ☐ STD
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Delay in healing

12. Do you have any disease, condition, or problem not listed above? ..... Please specify: _____	☐	☐
13. Are you required to take premeds prior to dental treatment?	☐	☐
Women:		
14. Are you pregnant?	☐	☐
15. Are you nursing?	☐	☐
16. 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.

Signature of Patient

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 rel:ase of your private health care and account information.

Name	Relation	Phone Number
Name	Relation	Phone Number

SUBMIT