Patient History and Information

TODAYS DATE _____

PLEASE PRINT CLEARLY

(Circle One)

Mr. Dr. Mrs. Ms. Miss

_____ _____ _____
Last Name First Name Middle Initial

E-mail Address: _____

Social Security # ___-___-___ Birthdate ___/___/___

Business Phone ( )_____ Home Phone ( )_____ Cell ( )_____

Home Address _____ City _____ Zip _____

Occupation _____ Employed by _____

Employer's Address _____ City _____ Zip _____

Name of Your Physician _____ City _____ Zip _____

Physician's Phone ( ) _____ Date of Last Physical _____

Name of Your Dentist _____ City _____ How Long? _____

In case of emergency,
we should call _____ Phone ( )_____ Relationship _____

Whom should we thank for referring you to our office? _____

Reason for this visit _____

PRIMARY INSURANCE

If you are covered by dental insurance, please complete this section.

Name of Insured _____

Social Security# ___-___-___ Birthdate ___/___/___

Group/ Union Name _____

Group or Policy # _____

Name of Ins. Co.
or Dental Plan _____

Ins. Co. Address _____

_____

Ins. Co. Phone ( ) _____

SECONDARY INSURANCE

*If you are covered by a **second** insurance, please complete this section.*

Name of Insured _____

Social Security# ___-___-___ Birthdate ___/___/___

Group / Union Name _____

Group or Policy # _____

Name of Ins. Co.
or Dental Plan _____

Ins. Co. Address _____

_____

Ins. Co. Phone ( ) _____

METHOD OF PAYMENT

Responsible party currently has an account with this office
❑ Yes ❑ No

❑ Payment in full at each appointment (cash or personal check)

❑ Payment in full at each appointment (❑ Visa ❑ MC)
Card # _____ Exp. Date _____

❑ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 90 days of the date of service, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to last month's balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____
❑ Adult Patient ❑ Guardian

_____
Date State Driver's License #

PATIENT INFORMATION

PATIENT NAME _____ **DATE** _____

Name of Your Physician _____ City _____ State ____ Zip _____

Physician's Phone ( ) _____ Date of Last Physical _____

Medical History

Are you under a physician's care now? Why? _____ Phone# _____

Have you ever been hospitalized or had a major operation? Discuss _____

Have you ever had a serious injury to your head or neck? Discuss _____

Are you taking any medications, pills or drugs? What? _____

Are you on a special diet? Discuss _____ Any diet drugs? _____

Are you allergic to any medications or substances? Please check box below _____

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____

WOMEN (Please check): ❑ Pregnant/trying ❑ Nursing ❑ Taking oral contraceptives Discuss _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	❑	❑	Bruise Easily	❑	❑	Emphysema	❑	❑	Yellow Jaundice	❑	❑	Cold Sores	❑	❑
Heart Murmur *	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Fever Blisters	❑	❑
Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Cancer	❑	❑	Renal Dialysis	❑	❑	Herpes	❑	❑
Angina/Chest Pain	❑	❑	Sickle Cell Disease	❑	❑	X-Ray Treatments (Radiation)	❑	❑	Thyroid Disease	❑	❑	Stroke	❑	❑
Heart Attack/Failure	❑	❑	Hemophilia (Bleeding Problem)	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Convulsions	❑	❑
Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Arthritis/Gout	❑	❑	Epilepsy or Seizures	❑	❑
Mitral Valve Prolapse *	❑	❑	Recent Blood Transfusion	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness	❑	❑
Scarlet Fever *	❑	❑	Swelling of Limbs	❑	❑	Recent Weight Loss	❑	❑	Pain in Jaw Joints	❑	❑	Glaucoma	❑	❑
Rheumatic Fever *	❑	❑	Lung Disease	❑	❑	Frequent Diarrhea	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths	❑	❑
Artificial Heart Valve *	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Artificial Joint *	❑	❑	Nervousness	❑	❑
Heart Pace Maker *	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Venereal Disease	❑	❑	Psychiatric Care	❑	❑
Heart Surgery	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	AIDS	❑	❑	Alzheimer's Disease	❑	❑
High Blood Pressure	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	HIV Positive	❑	❑	Allergies (Medicines)	❑	❑
Low Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (Infectious)	❑	❑	Alcohol Addiction	❑	❑	Allergies (Pollen/Dust)	❑	❑
Blood Disease	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Drug Addiction	❑	❑	Hives or Rash	❑	❑

Have you ever had any other serious illness not checked above? Discuss _____ Yes ❑ No ❑

Do you wish to talk to the dentist privately about any problem? _____ Yes ❑ No ❑

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____

❑ SEE REVERSE SIDE

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Pratices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____