PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767/27000

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

REGISTRATION

DENTAL HISTORY

Please check any of the following that apply to you:

Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL
Headaches, ear aches, neck or jaw joint pain ☐
Mouth ulcers or cold sores ☐
Teeth or fillings breaking ☐
Grinding or clenching teeth ☐
Bleeding, swollen or irritated gums ☐
Loose, tipped or shifting teeth ☐
Bad breath ☐

Do you have or have you had any of the following?

Dentures ☐
Partial dentures ☐
Braces ☐
Gum treatments ☐

Please share the following dates:

Your last cleaning ___/___
Your last oral cancer screening ___/___
Your last complete X-Rays ___/___

Name of Previous Dentist _____
City _____ **State** _____
Phone Number _____
What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐
Do you smoke or use chewing tobacco? ☐
How much? For how long?
If I could change my smile, I would: ☐
Make my teeth whiter ☐
Make my teeth straighter ☐
Close spaces ☐
Replace metal fillings with tooth colored restorations ☐
Repair chipped teeth ☐
Replace missing teeth ☐
Replace old crowns that don't match ☐
Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?
_____
_____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)
☐ Anemia
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness/Fainting
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Glaucoma
☐ Heart Conditions
☐ Heart Murmur
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Phen Fen (1 month +)
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizures
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ OTHER (please list):
_____
_____
_____
_____
_____
_____

For WOMEN Only

❑ Birth Control Pills
❑ Breast-feeding
❑ Pregnant
1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin
☐ Erythromycin
☐ Latex
☐ Local Anesthetic
☐ Nitrous Oxide
☐ Penicillin
☐ Codeine
☐ Other: _____

What medications are you currently taking?
_____
_____

Are you under a physician's care? For what?
_____
_____

Family Physician _____ **Phone Number** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: