PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

How Did You Hear About Our Office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Subscriber ID_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Subscriber ID _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date _____

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information about you can be used and disclosed and how you can get access to this information. Please read it carefully, we consider the privacy of your health information important.

By law, it is required to provide the patient's privacy notice. This notice describes how your medical history can be used by our office. It also explains how you can get access to your medical history.

As A Patient You Have the Right To:

1. The right to review your information.
2. The right to correct your information.
3. The right to have your information restricted.
4. The right to require that your information be confidential
5. The right to report disclosures of your information.
6. The right to receive a copy of this notice.

We want to ensure that your medical information is safe with us. This Patient Privacy notice contains confidential information.

Recognition of Notice to Patient Privacy

I acknowledge that I have reviewed the patient's privacy notice, I understand that the office will inform me if there are changes to this notice. For any reason if it becomes modified or changed in any way, I will receive a copy.

_____

Patient Name

_____

Patient or Guardian's Signature