

WELCOME

NAME: _____ NICKNAME: _____ DATE: _____
 ADDRESS: _____ CITY: _____ STATE/ZIP _____
 BIRTHDATE: _____ SOC SEC #: _____
 MALE FEMALE MINOR MARRIED DIVORCED
 HAVE YOU EVER BEEN A PATIENT OF OUR PRACTICE?: Yes No
 EMPLOYER: _____ OCCUPATION: _____
 REFERRED BY: _____
 HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____
 WHERE DO YOU PREFER TO RECEIVE CALLS: Home Cell Work
 WHEN IS THE BEST TIME TO REACH YOU: TIME: _____ DAYS: _____
 E-MAIL _____
 EMERGENCY CONTACT: NAME: _____ RELATIONSHIP _____
 PHONE NUMBER: HOME _____ CELL _____
 E-MAIL _____
 WHO IS RESPONSIBLE FOR THE ACCOUNT _____
 NAME: _____ RELATIONSHIP _____
 BIRTHDATE _____ SOC SEC# _____ PHONE _____
 ADDRESS _____ CITY/STATE/ZIP _____
 EMPLOYER _____ WORK PHONE _____

PRIMARY INSURANCE COMPANY _____ GROUP # _____ ID # _____ NAME OF SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____ SUBSCRIBER BIRTHDATE _____ SOC SEC # <u>xxx-xx-xxxx</u> EMPLOYER _____ HAVE YOU USED THIS INSURANCE AT ANY OTHER DENTAL OFFICE? <input type="radio"/> Yes <input type="radio"/> No	SECONDARY INSURANCE COMPANY _____ GROUP # _____ ID # _____ NAME OF SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____ SUBSCRIBER BIRTHDATE _____ SOC SEC # <u>xxx-xx-xxxx</u> EMPLOYER _____ HAVE YOU USED THIS INSURANCE AT ANY OTHER DENTAL OFFICE? <input type="radio"/> Yes <input type="radio"/> No
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I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION (INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE) TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURE OF PATIENT OR PARENT OR GUARDIAN OF MINOR _____

PLEASE PRINT NAME: _____

DATE _____

MEDICAL HISTORY FORM
* Note: All Responses in BLUE are required!

NAME: _____ BIRTH DATE: _____ DATE: _____

FOR THE FOLLOWING QUESTIONS, SELECT "YES", "NO", OR A SPECIFIC ITEM. YOUR ANSWERS ARE CONFIDENTIAL.

WHO IS YOUR PRIMARY MEDICAL PHYSICIAN? _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

IN THE PAST 5 YEARS, HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED?
 DESCRIBE: _____

LIST ALL PRESCRIPTION DRUGS, NON-PRESCRIPTION DRUGS OR VITAMINS YOU CURRENTLY TAKE:

ARE YOU ALLERGIC TO:

ASPIRIN/ACETAMINOPHEN/IBUPROFEN	<input type="radio"/> Yes <input type="radio"/> No
CODEINE, DEMEROL, OTHER NARCOTICS	<input type="radio"/> Yes <input type="radio"/> No
BARBITURATES, SEDATIVES OR SLEEPING PILLS	<input type="radio"/> Yes <input type="radio"/> No
PENICILLIN, ERYTHROMYCIN, TETRACYCLINE, OTHER ANTIBIOTICS	<input type="radio"/> Yes <input type="radio"/> No
SULFA DRUGS	<input type="radio"/> Yes <input type="radio"/> No
LATEX	<input type="radio"/> Yes <input type="radio"/> No
METALS OF ANY KIND	<input type="radio"/> Yes <input type="radio"/> No
LOCAL ANESTHETIC	<input type="radio"/> Yes <input type="radio"/> No
OTHER ALLERGIES (LIST): _____	<input type="radio"/> Yes <input type="radio"/> No

PLEASE SELECT "YES" OR "NO" TO INDICATE IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

HEART CONDITIONS: ANGINA/CHEST PAIN (UPON EXERTION) <input type="radio"/> Yes <input type="radio"/> No ARTIFICIAL VALVE(S) <input type="radio"/> Yes <input type="radio"/> No HEART VALVE PROBLEMS <input type="radio"/> Yes <input type="radio"/> No HEART ATTACK/DISEASE/SURGERY <input type="radio"/> Yes <input type="radio"/> No HEART MURMUR <input type="radio"/> Yes <input type="radio"/> No HIGH/LOW BLOOD PRESSURE <input type="radio"/> Yes <input type="radio"/> No PACEMAKER <input type="radio"/> Yes <input type="radio"/> No RHEUMATIC FEVER <input type="radio"/> Yes <input type="radio"/> No INFECTIVE (BACTERIAL) ENDOCARDITIS <input type="radio"/> Yes <input type="radio"/> No	RESPIRATORY PROBLEMS: ASTHMA <input type="radio"/> Yes <input type="radio"/> No HAY FEVER <input type="radio"/> Yes <input type="radio"/> No SINUS PROBLEMS <input type="radio"/> Yes <input type="radio"/> No LUNG PROBLEMS <input type="radio"/> Yes <input type="radio"/> No SHORTNESS OF BREATH <input type="radio"/> Yes <input type="radio"/> No TUBERCULOSIS <input type="radio"/> Yes <input type="radio"/> No EMPHYSEMA/COPD <input type="radio"/> Yes <input type="radio"/> No
LIVER PROBLEMS: LIVER DISEASE <input type="radio"/> Yes <input type="radio"/> No HEPATITIS <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D <input type="radio"/> E <input type="radio"/> Yes <input type="radio"/> No	DIGESTIVE PROBLEMS: ACID REFLUX, G.E.R.D., HYPERACIDITY <input type="radio"/> Yes <input type="radio"/> No ULCER(S) <input type="radio"/> Yes <input type="radio"/> No WEIGHT LOSS <input type="radio"/> Yes <input type="radio"/> No WEIGHT GAIN <input type="radio"/> Yes <input type="radio"/> No
ONCOLOGIC PROBLEMS/TREATMENT: CANCER (TYPE): _____ <input type="radio"/> Yes <input type="radio"/> No CHEMOTHERAPY <input type="radio"/> Yes <input type="radio"/> No RADIATION THERAPY <input type="radio"/> Yes <input type="radio"/> No	JOINT PROBLEMS: ARTHRITIS <input type="radio"/> Yes <input type="radio"/> No BACK PROBLEMS <input type="radio"/> Yes <input type="radio"/> No ARTIFICIAL JOINT/JOINT REPLACEMENT <input type="radio"/> Yes <input type="radio"/> No
THYROID/PANCREAS/KIDNEY PROBLEMS: HYPERTHYROIDISM <input type="radio"/> Yes <input type="radio"/> No HYPOTHYROIDISM <input type="radio"/> Yes <input type="radio"/> No DIABETES TYPE I OR II <input type="radio"/> Yes <input type="radio"/> No SLOW HEALING <input type="radio"/> Yes <input type="radio"/> No KIDNEY DISEASE <input type="radio"/> Yes <input type="radio"/> No	NERVOUS PROBLEMS: EPILEPSY <input type="radio"/> Yes <input type="radio"/> No DIZZINESS <input type="radio"/> Yes <input type="radio"/> No NEUROLOGICAL DISORDER(S) <input type="radio"/> Yes <input type="radio"/> No PSYCHOLOGICAL DISORDER(S) <input type="radio"/> Yes <input type="radio"/> No ANOREXIA/BULLIMIA <input type="radio"/> Yes <input type="radio"/> No
BACTERIAL AND VIRAL INFECTIONS/STD/STI: CHICKEN POX/SHINGLES <input type="radio"/> Yes <input type="radio"/> No ORAL HERPES (COLD SORES) <input type="radio"/> Yes <input type="radio"/> No OTHER STD/STI: _____ <input type="radio"/> Yes <input type="radio"/> No	IMMUNE SYSTEM PROBLEMS: HIV <input type="radio"/> Yes <input type="radio"/> No AIDS <input type="radio"/> Yes <input type="radio"/> No AUTOIMMUNE DISEASE: _____ <input type="radio"/> Yes <input type="radio"/> No
BLOOD DISORDERS: HEMOPHILIA <input type="radio"/> Yes <input type="radio"/> No EXCESSIVE BLEEDING <input type="radio"/> Yes <input type="radio"/> No ANEMIA <input type="radio"/> Yes <input type="radio"/> No BLOOD TRANSFUSION <input type="radio"/> Yes <input type="radio"/> No	SUBSTANCE USE: ALCOHOL ABUSE <input type="radio"/> Yes <input type="radio"/> No TOBACCO (SMOKING OR CHEWING) <input type="radio"/> Yes <input type="radio"/> No MARIJUANA (SMOKING, EDIBLES, ETC.) <input type="radio"/> Yes <input type="radio"/> No OTHER SUBSTANCES: _____ <input type="radio"/> Yes <input type="radio"/> No

DO YOU HAVE, OR HAVE YOU HAD, ANY OTHER MEDICAL CONDITIONS THAT WERE NOT ADDRESSED ABOVE?

DENTAL HISTORY
* Note: All Responses in BLUE are required!

PLEASE SELECT "YES" OR "NO" AS TO WHETHER YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

ORAL TISSUES AND CONDITIONS: BAD BREATH/HALITOSIS <input type="radio"/> Yes <input type="radio"/> No CANKER SORES IN MOUTH <input type="radio"/> Yes <input type="radio"/> No GROWTHS/BLISTERS/SORES IN MOUTH <input type="radio"/> Yes <input type="radio"/> No BLEEDING GUMS <input type="radio"/> Yes <input type="radio"/> No PERIODONTAL (GUM) DISEASE <input type="radio"/> Yes <input type="radio"/> No	TRAUMA, TREATMENT AND APPLIANCES: INJURY TO FACE/JAW: _____ <input type="radio"/> Yes <input type="radio"/> No BITEGUARD/SPORTSGUARD <input type="radio"/> Yes <input type="radio"/> No ORTHODONTICS (BRACES, INVISALIGN, ETC.) <input type="radio"/> Yes <input type="radio"/> No ORAL SURGERY: _____ <input type="radio"/> Yes <input type="radio"/> No PARTIAL/FULL DENTURE(S) <input type="radio"/> Yes <input type="radio"/> No
TMJ SYMPTOMS AND TREATMENT: FREQUENT HEADACHES/NECKACHES <input type="radio"/> Yes <input type="radio"/> No CLICKING OR POPPING JAW <input type="radio"/> Yes <input type="radio"/> No TIRED, SORE OR PAINFUL JAW JOINT/TMJ <input type="radio"/> Yes <input type="radio"/> No PAIN AROUND EARS/TEMPLES <input type="radio"/> Yes <input type="radio"/> No CLENCHING OR GRINDING OF TEETH <input type="radio"/> Yes <input type="radio"/> No TMJ TREATMENT <input type="radio"/> Yes <input type="radio"/> No NIGHTGUARD/NTI <input type="radio"/> Yes <input type="radio"/> No	TOOTH ISSUES: PAIN WITH CHEWING <input type="radio"/> Yes <input type="radio"/> No FOOD PACKING BETWEEN TEETH <input type="radio"/> Yes <input type="radio"/> No BROKEN TOOTH OR FILLING <input type="radio"/> Yes <input type="radio"/> No SENSITIVITY TO: HOT, COLD, SWEET, BITING <input type="radio"/> Yes <input type="radio"/> No VAGUE ACHE/TOOTHACHE <input type="radio"/> Yes <input type="radio"/> No SWELLING <input type="radio"/> Yes <input type="radio"/> No LOOSE TOOTH <input type="radio"/> Yes <input type="radio"/> No
RESPIRATION RELATED: DRY MOUTH <input type="radio"/> Yes <input type="radio"/> No MOUTH BREATHING <input type="radio"/> Yes <input type="radio"/> No SNORING <input type="radio"/> Yes <input type="radio"/> No SLEEP APNEA <input type="radio"/> Yes <input type="radio"/> No C-PAP MACHINE <input type="radio"/> Yes <input type="radio"/> No	TREATMENT CONSIDERATIONS: DENTAL ANXIETY <input type="radio"/> Yes <input type="radio"/> No EXCESSIVE GAG REFLEX <input type="radio"/> Yes <input type="radio"/> No HARD TO GET NUMB <input type="radio"/> Yes <input type="radio"/> No CLAUSTROPHOBIC <input type="radio"/> Yes <input type="radio"/> No DIFFICULTY OPENING MOUTH <input type="radio"/> Yes <input type="radio"/> No

LAST VISIT TO DENTIST: _____ FOR: _____

LAST DENTAL HYGIENE APPOINTMENT: _____ WHERE: _____

DO YOU HAVE RECORDS/XRAYS AT ANOTHER OFFICE THAT WE CAN GET FOR YOU? _____

WHAT IS YOUR PRIMARY REASON FOR SEEKING DENTAL TREATMENT TODAY?

WHAT DO YOU WISH YOU COULD CHANGE ABOUT YOUR TEETH?

WHAT HAVE YOU LIKED ABOUT ANY DENTAL OFFICE YOU'VE VISITED IN THE PAST?

WHAT HAVE YOU LIKED LEAST ABOUT ANY OTHER OFFICE YOU'VE BEEN TO?

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICATIONS CHANGE, I WILL INFORM MY DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.
 CASH CHECK CREDIT CARD CARECREDIT DOCPAY SPRINGSTONE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices.

You may refuse to sign this acknowledgement

Print Name _____ Date _____

Signature _____

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

___ An emergency situation prevented us from obtaining acknowledgement

___ Other _____

Employee Name _____ Date _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

THE INFORMATION YOU HAVE PROVIDED WILL HELP US SERVE YOUR DENTAL NEEDS MORE EFFECTIVELY AND EFFICIENTLY. IF YOU HAVE ANY QUESTIONS AT ANYTIME, PLEASE ASK- WE ARE ALWAYS HAPPY TO HELP.

