DENTAL HISTORY

Why are you changing your dentist?

_____

How long ago was your last visit to your dentist? ☐ 1 month ☐ 3 months ☐ 6 months

☐ 1 year ☐ 2 years ☐ 3 years ☐ More than 3 years ☐ I've never seen a dentist

Name of previous dentist:

_____

How did you find us? ☐ Other patient ☐ Dental Office ☐ Yelp ☐ Google ☐ Internet

☐ Yellow Pages ☐ Mailer ☐ Work ☐ School ☐ Insurance Co ☐ Other

Reason for today's visit: ☐ Check-up ☐ Cleaning ☐ Pain ☐ Other _____

Have you ever had a bad experience at the dentist? ☐ Yes ☐ No

Have you had any complications following treatment? ☐ Yes ☐ No

Have you had any unfavorable reactions to dental anesthetic? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes, slightly ☐ Yes, Moderately ☐ Yes, Extremely

Are your teeth sensitive to cold or hot temperatures? ☐ Yes ☐ No

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Are you aware of sores or irritated areas in the mouth? ☐ Yes ☐ No

Have you ever been treated for Periodontal Disease? ☐ Yes ☐ No

How often do you brush? ☐ Three times a day ☐ Every time I eat ☐ Never ☐ Occasionally

☐ Once a day ☐ Twice a day

How often do you floss? ☐ Three times a day ☐ Every time I eat ☐ Never ☐ Occasionally

☐ Once a day ☐ Twice a day

Do you like your smile? ☐ Yes ☐ No

DENTAL HISTORY

If you could change your smile, what would you like to change? ☐ **Change color of my teeth**

☐ **Close spaces or restore worn out or broken teeth** ☐ **Change the shape of my teeth**

☐ **Change the position or alignment of my teeth**

Other:

I am interested in: ☐ **Teeth whitening** ☐ **Cosmetic evalution** ☐ **Replacement of missing teeth**

☐ **Straight teeth** ☐ **Sedation** ☐ **White filling** ☐ **Home care** ☐ **Breath control**

Other:

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about:

Patient's Signature:

Relationship to the patient: ☐ **Patient** ☐ **Parent** ☐ **Grandparent** ☐ **Guardian** ☐ **Sibling**

☐ **Legal Representative**

Name if not the patient:

MEDICAL HISTORY

MEDICAL CONDITIONS:

1. Anemia ☐
2. Arthritis ☐
3. Artifical Joints ☐
4. Asthma ☐
5. Blood disease ☐
6. Cancer ☐
7. Diabetes ☐
8. Dizziness ☐
9. Epilepsy ☐
10. Excessive Bleeding ☐
11. Fainting ☐
12. Glaucoma ☐
13. Head Injuries ☐
14. Heart Disease ☐
15. Heart Murmur ☐
16. Hepatitis ☐
17. High Blood Pressure ☐
18. HIV ☐
19. Jaundice ☐
20. Kidney Disease ☐
21. Liver Disease ☐
22. Mental Disorders ☐
23. Pacemaker ☐
24. Pregnancy ☐
25. Radiation Treatment ☐
26. Respiratory Problems ☐
27. Rheumatic Fever ☐
28. Rheumatism ☐
29. Sinus Problems ☐
30. Stomach Problems ☐
31. Stroke ☐
32. Tuberculosis ☐
33. Tumors ☐
34. Ulcers ☐
35. Venereal Disease ☐

Do you have any other health problems? ☐ Yes ☐ No

ALLERGIES:

1. Acrylic ☐
2. Clindamycin ☐
3. Ibuprofen ☐
4. Sulfa ☐
5. Amoxicillin ☐
6. Codeine ☐
7. Latex ☐
8. Tetracycline ☐
9. Anesthetics ☐
10. Dental Anesethrics ☐
11. Metals ☐
12. Aspirin ☐
13. Erythromycin ☐
14. Penicillin ☐

Do you have any other allergies not listed above? ☐ Yes ☐ No

MEDICATIONS:

1. Adderall ☐
2. Amoxicillin ☐
3. Codeine ☐
4. Ibuprofen ☐
5. Oxycontin ☐
6. Prozac ☐
7. Tylenol ☐
8. Albuterol ☐
9. Aspirin ☐
10. Doxycycline ☐
11. Klonopin ☐
12. Paxil ☐
13. Ritalin ☐
14. Vicodin ☐
15. Alprazolam ☐
16. Bactrim ☐
17. Flomax ☐
18. Lexapro ☐
19. Penicillin ☐
20. Soma ☐
21. Zithromax ☐
22. Ambien ☐
23. Cipro ☐
24. Hydrocodone ☐

MEDICAL HISTORY

25. Lipitor _____ ☐ 27. Tramadol _____ ☐

26. Percocet _____ ☐ 28. Zoloft _____ ☐

Please specify other medications, pills or drugs not listed above:

Have you ever been hospitalized or had a major surgery? ☐ Yes ☐ No

Do you have a physician (medical doctor)? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use alcoholic beverages? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Have you ever taken a diet drug such Fen-Phen? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No

Women: Do you take birth control medications? ☐ Yes ☐ No

Women: Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Patient's Signature:

Relationship to the patient: ☐ Patient ☐ Parent ☐ Grandparent ☐ Guardian ☐ Sibling

Name if not the patient:

INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No ☐ I am the responsible party

PRIMARY DENTAL INSURANCE HOLDER

Name _____

Address _____

Birthday _____ **SSN** _____

Relationship to the patient: ☐ Patient ☐ Parent ☐ Grandparent ☐ Guardian ☐ Sibling ☐ Legal Representative

PRIMARY DENTAL INSURANCE

Employer name _____ **Employer Address** _____

Insurance Company _____ **Phone Number** _____

Subscriber ID _____ **Group Number** _____

Do you have secondary dental insurance? ☐ Yes ☐ No

Employer name _____ **Employer Address** _____

Insurance Company _____ **Phone Number** _____

Subscriber ID _____ **Group Number** _____

Patient's Signature:

_____

Relationship to the patient: ☐ Patient ☐ Parent ☐ Grandparent ☐ ☐ Sibling ☐ Legal Representative

Name if not the patient:

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

Notice of Privacy Practices Acknowledgement and Consent

_____

How do you want to be addressed when summoned from the reception area?

☐ **First Name Only** ☐ **Proper Sir Name** ☐ **Other**

I authorize the following individuals (example: spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

PERSON 1

Name _____ **Relationship** _____

PERSON 2

Name _____ **Relationship** _____

PERSON 3

Name _____ **Relationship** _____

I authorize contact from this office to confirm my appointments, treatments and billing information via:

☐ **Cell Phone Confirmation** ☐ **Text Message to My Cell Phone** ☐ **Home Phone Confirmation**

☐ **Email Confirmation** ☐ **Work Phone Confirmation** ☐ **Any of the Above**

I authorize information about my health be conveyed via:

☐ **Cell Phone Confirmation** ☐ **Text Message to My Cell Phone** ☐ **Home Phone Confirmation**

☐ **Email Confirmation** ☐ **Work Phone Confirmation** ☐ **Any of the Above**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I approve being contacted about special services, events, fund raising efforts or new health information on behalf of this office via:

☐ **Phone Message** ☐ **Text Message** ☐ **Email**

☐ **Any of the Above** ☐ **None of the Above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

Patient's Signature

_____

Relationship to the patient: ☐ **Patient** ☐ **Parent** ☐ **Grandparent** ☐ ☐ **Sibling**

☐ **Legal Representative**

Name if not the patient:

_____

FOR OFFICE USE ONLY

As Privacy Officer, I attempted to obtain patient's (or representative's) written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ **Emergency Treatment** ☐ **I could not communicate with the patient**

☐ **Patient refused to sign** ☐ **Patient was unable to sign** ☐ **Other**

Name of Privacy Officer:

_____

PATIENT INFORMATION

First Name _____ **Last Name** _____

Middle Name/Initial _____ **Preferred Name** _____

Address (Line 1) _____

Address (Line 2) _____

Birthday _____ **SSN** _____ **Driver's License** _____

Gender ☐ **Male** ☐ **Female** **Family Status** ☐ **Single** ☐ **Married** ☐ **Child** ☐ **Other**

Email _____ **Home phone** _____

Work phone _____ **Mobile phone** _____

Address (Line 1) _____

Address (Line 2) _____

City _____ **State** _____ **Zip** _____

Student Status ☐ **Non Student** ☐ **Full-time** ☐ **Part-time**

Emergency Contact Name _____ **Physician's Name** _____

Preferred Pharmacy Name _____

Communication Preferences ☐ **I want to receive emails** ☐ **I want to receive text messages**

Referred By _____ **Patient Signature** _____

Relationship to the patient ☐ **Patient** ☐ **Parent** ☐ **Grandparent** ☐ **Guardian**

☐ **Sibling** ☐ **Legal representative**