

# Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Is this person currently a patient in our office?  Yes  No  
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.  
 Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
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 \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	10. Are you wearing contact lenses? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/>	
3. Are you taking any medication(s) including non-p-cription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics .....	<input type="checkbox"/>	
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	
4. Have you ever taken Pen-Phen/Redux? .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates .....	<input type="checkbox"/>	
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	
7. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	
8. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.) .....	<input type="checkbox"/>	
9. Do you have or have you had any of the following?			Latex Rubber .....	<input type="checkbox"/>	
High Blood Pressure .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>	
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .....	<input type="checkbox"/>	
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:		
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/>	
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing? .....	<input type="checkbox"/>	
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives? .....	<input type="checkbox"/>	
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	8. Do you have frequent headaches? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ea ; side of face) .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 providers and/or 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.

**X**  
 Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments _____
Signature _____ Date _____

# Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, \_\_\_\_\_, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Please Print

Relationship to Patient: \_\_\_\_\_

### For Office Use Only

We made a good-faith effort to obtain an acknowledgment of \_\_\_\_\_'s receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- Patient refused to sign (date of refusal) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Communications barriers prohibited obtaining an acknowledgment.
- An emergency situation prevented us from obtaining an acknowledgment.
- Other \_\_\_\_\_

Attempt was made by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Important Note: This is approved for use by the purchaser only. This form may not be shared publicly or with third parties.

# Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## Patient Authorization

I, \_\_\_\_\_, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize \_\_\_\_\_  
Name of individual(s) and/or organization providing information

to release the above-described information to \_\_\_\_\_  
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

\_\_\_\_\_

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on \_\_\_\_\_, If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.  
Expiration date or event

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

## Patient or Personal Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Please Print

Relationship to Patient: \_\_\_\_\_

## For Office Use Only

Received by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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