Patient Information

Patient Name: ____

Last First Middle Preferred Name

Address: ____

City State Zip

Home Phone: ____________ Work: ______________ Cell: ______________

Birthdate: __________ Sex: M F Marital Status: S M D W Soc. Sec. #: __________

Employer: ____________________ Email Address: ____________________

Whom may we thank for referring you to our office? ______________________________

____

Dental Ins. Company Name (Receptionist will make copy of card) Insured Name Insured S.S. Number Insured D.O.B.

Medical History

To the best of your knowledge, have you ever had or suspected any of the following: (check if yes)

☐ High Blood Pressure	☐ Diabetes	☐ Tuberculosis	☐ Heart Condition	☐ Chest Pain
☐ Scarlet Fever	☐ Anemia	☐ Heart Attack	☐ Heart Murmur	☐ Artificial Joints
☐ Seizures/Epilepsy	☐ Stroke	☐ AIDS/HIV positive	☐ Bleeding Disorder	☐ Lung Disease
☐ Depression	☐ Allergies	☐ Bladder Problems	☐ Weakness/Fatigue	☐ Cancer
☐ Sinus Problems	☐ Fainting	☐ Emphysema	☐ Kidney Problems	☐ Radiation Treatment
☐ Thyroid Problem	☐ Asthma	☐ Stomach Ulcers	☐ Bruise Easily	☐ Rheumatic Fever
☐ Back Problems	☐ Hepatitis	(Type: A B C)		

Current Medications: ____

____

Have you ever been told that you need antibiotics before dental treatment? YES NO

Hospitalizations, Surgeries, Injuries: ____________________ Date: __________

Allergies: ☐ None ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal

☐ Latex ☐ Sulfa ☐ Other ____________________

Women: Are you pregnant or trying to get pregnant? YES NO

Name of primary care physician: ____________________ Phone #: ______________

Emergency Contact: ____

Name Relationship Phone #

Dental History

Do you have dental examinations on a routine basis? _________ Last visit ___________ Last X-rays? ______________

Chief Concern: ____

Is there anything about your smile you don't like? ____

Is there anything about the appearance of your teeth that you'd like to change? Color Position Spacing

Do you have any old fillings or dental work that you don't like? ____

Are you nervous about dental treatment? ____________ Have you ever used Nitrous Oxide (gas) for treatment? ______

Have you ever been told you clench or grind your teeth during sleep? _________

X ____ Date: ______________________

Patient Signature (Parent or Guardian)

Notice of Privacy Practices
Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _______________________________

Date: __________________

Relationship to patient (if signed by a personal representative of patient):

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