## PATIENT INFORMATION

Name	Name			
Home Phone: Work Phone: Cell Phone: Birth Date: Social Security # Sex (M/F) Marital Status  Employer Email Address  PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)  Name Billing Address  City State Zip Marital Status  Home Phone: Birth Date: Social Security # Sex (M/F) Marital Status  Relationship to Patient Email Address  DENTAL INSURANCE COVERAGE (Y/N) Sex (M/F) Marital Status  Relationship to "Referred By" below.  YES Provide an insurance card to the desk and answer the following questions.  PERSON PROVIDING INSURANCE (IF DIFFERENT THAN PATIENT)  Name Employer  Birth Date Social Security # Relationship to Patient Work Phone  MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) Marital Status  MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) Marital Status  MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) Marital Status  MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) Marital Status Security # Relationship to Patient Work Phone  MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) Marital Status Security # Marital Status Securit				
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Name	Employer		Email Address	
Name				
Name	PERSON RESPONSIBLE	FOR BILL (IF DIFFERE	NT THAN PATIENT)	
City				
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## PATIENT MEDICAL HISTORY

PHYSICIAN	OFFICE PHONE		DATE OF LAST EXAM
	YES NO		
1. ARE YOU UNDER MEDICAL TREATMENT NO	w?	7.	ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.
<ol> <li>HAVE YOU EVER BEEN HOSPITALIZED FOR SURGICAL OPERATION OR SERIOUS ILLNE</li> </ol>			ANT DROGS: IF TES, FEEASE SFEORT.
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE	? 🗆 🗆		
IF YES, WHAT MEDICATION(S) ARE YOU TAI	(ING?	- 8.	WHEN WAS YOUR LAST COMPLETE PHYSICAL?
4. DO YOU USE TOBACCO?		- 9.	WOMEN ONLY:  A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?
5. DO YOU USE ALCOHOL, COCAINE OR OTH	ER DRUGS?		B) ARE YOU NURSING?
6. ARE YOU WEARING CONTACT LENSES?			C) ARE YOU TAKING BIRTH CONTROL PILLS?
10. PLEASE INDICATE WHICH OF THE FOLLOW	ING APPLIES TO YOU.	CHECK	ONLY IF ANSWER IS YES.
HEART ATTACK CAP RHEUMATIC FEVER HE/ SWOLLEN ANKLES AND FAINTING / SEIZURES MIT ASTHMA AND	ART DISEASE  RDIAC PACEMAKER  ART MURMUR  GINA  FRAL VALVE PROLA  EMIA  PHYSEMA	PSE	□ CHEST PAINS       □ KIDNEY DISEASES         □ EASILY WINDED       □ AIDS OR HIV INFECTION         □ STROKE       □ THYROID PROBLEM         □ HAY FEVER / ALLERGIES       □ HEPATITIS / JAUNDICE         □ TUBERCULOSIS       □ SEXUALLY TRANSMITTED DISEAS         □ RADIATION THERAPY       □ STOMACH TROUBLES / ULCERS
☐ EPILEPSY / CONVULSIONS ☐ CAI ☐ LEUKEMIA ☐ ART ☐ DIABETES ☐ JOI  COMMENTS	NCER THRITIS NT REPLACEMENT OF	R IMPLAN	GLAUCOMA RESPIRATORY PROBLEMS RECENT WEIGHT LOSS OTHER LIVER DISEASE THEART TROUBLE
PATIENT DENTAL HIPLEASE INDICATE WHICH OF THE FOLLOWING 1. DO YOUR GUMS BLEED WHILE BRUSHING OF THE TO HOT OR CO.	STORY  APPLIES TO YOU. CHER FLOSSING?  LD LIQUIDS/FOODS?	IECK ONL	RECENT WEIGHT LOSS OTHER
PATIENT DENTAL HIP  PLEASE INDICATE WHICH OF THE FOLLOWING  1. DO YOUR GUMS BLEED WHILE BRUSHING OF  2. ARE YOUR TEETH SENSITIVE TO HOT OR CO  3. ARE YOUR TEETH SENSITIVE TO SWEET OR	STORY  APPLIES TO YOU. CHE FLOSSING?  LD LIQUIDS/FOODS?  SOUR LIQUIDS/FOODS	IECK ONL	RECENT WEIGHT LOSS OTHER LIVER DISEASE T HEART TROUBLE  Y IF ANSWER IS YES.  B. DO YOU HAVE FREQUENT HEADACHES?
PATIENT DENTAL HIP  PLEASE INDICATE WHICH OF THE FOLLOWING  1. DO YOUR GUMS BLEED WHILE BRUSHING OF  2. ARE YOUR TEETH SENSITIVE TO HOT OR CO  3. ARE YOUR TEETH SENSITIVE TO SWEET OR  4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH	STORY  APPLIES TO YOU. CHARLOSING?  LD LIQUIDS/FOODS?  SOUR LIQUIDS/FOODS?	IECK ONL	RECENT WEIGHT LOSS OTHER LIVER DISEASE THEART TROUBLE  Y IF ANSWER IS YES.  8. DO YOU HAVE FREQUENT HEADACHES? 9. DO YOU CLENCH OR GRIND YOUR TEETH? 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS
PATIENT DENTAL HI PLEASE INDICATE WHICH OF THE FOLLOWING 1. DO YOUR GUMS BLEED WHILE BRUSHING OF 2. ARE YOUR TEETH SENSITIVE TO HOT OR CO 3. ARE YOUR TEETH SENSITIVE TO SWEET OR 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH' 5. DO YOU HAVE ANY SORES OR LUMPS IN OR	STORY  APPLIES TO YOU. CHER FLOSSING?  LD LIQUIDS/FOODS?  SOUR LIQUIDS/FOODS?  NEAR YOUR MOUTH?	IECK ONL	RECENT WEIGHT LOSS OTHER LIVER DISEASE THEART TROUBLE  Y IF ANSWER IS YES.  8. DO YOU HAVE FREQUENT HEADACHES? 9. DO YOU CLENCH OR GRIND YOUR TEETH? 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?
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□ EPILEPSY / CONVULSIONS □ CAI □ LEUKEMIA □ ART □ DIABETES □ JOI  COMMENTS  PATIENT DENTAL HI  PLEASE INDICATE WHICH OF THE FOLLOWING  1. DO YOUR GUMS BLEED WHILE BRUSHING OF  2. ARE YOUR TEETH SENSITIVE TO HOT OR CO  3. ARE YOUR TEETH SENSITIVE TO SWEET OR  4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH  5. DO YOU HAVE ANY SORES OR LUMPS IN OR  6. HAVE YOU HAD ANY HEAD, NECK OR JAW IN  7. HAVE YOU EVER EXPERIENCED ANY OF THE PROBLEMS IN YOUR JAW?	STORY  APPLIES TO YOU. CHE R FLOSSING? LD LIQUIDS/FOODS? SOUR LIQUIDS/FOODS? NEAR YOUR MOUTH? JURIES?	IECK ONL	RECENT WEIGHT LOSS OTHER LIVER DISEASE HEART TROUBLE  Y IF ANSWER IS YES.  8. DO YOU HAVE FREQUENT HEADACHES? 9. DO YOU CLENCH OR GRIND YOUR TEETH? 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? 12. HAVE YOU HAD ANY ORTHODONTIC WORK? 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?

## PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES CONSENT & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we <u>may not be allowed</u> to process your insurance claims.

The undersigned acknowledges 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 PERSONAL HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITYS IN THE FUTURE.

Patient's Name (print)			
	Signature (Parent or Guardian signature for minors)		
	LEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: includes stepparents, grandparents and any caretakers who can have access to this patient's records):		
Name	:Relationship:		
Name	: Relationship:		
recon	signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may namend products or services to promote your improved health. This office may or may not receive third party ration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.		
OFFICE US As Privacy (	SE ONLY  Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:  It was emergency treatment  I could not communicate with the patient  The patient refused to sign  The patient was unable to sign because:  Other (please describe)		

Signature of Privacy Officer