

## Patient Information

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  Male  Female  
 Social Security # \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Patient Health Information

Have you ever had any of the following? Please check those that apply:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Allergies<br><input type="checkbox"/> Codeine<br><input type="checkbox"/> Penicillin<br><input type="checkbox"/> Aspirin<br><input type="checkbox"/> Latex<br><input type="checkbox"/> Acid Reflux<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial Joints<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Blood Pressure<br><input type="checkbox"/> High<br><input type="checkbox"/> Low | <input type="checkbox"/> Cancer<br><input type="checkbox"/> Circulatory Problems<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness / Fainting<br><input type="checkbox"/> Epilepsy / Seizures<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Habits<br><input type="checkbox"/> Alcohol<br><input type="checkbox"/> Drugs<br><input type="checkbox"/> Smoking / Tobacco<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Heart Disease / Attack | <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> A<br><input type="checkbox"/> B<br><input type="checkbox"/> C<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> HIV Positive / Aids<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Sickle Cell / Trait<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Sexually Transmitted Disease<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid Condition<br><input type="checkbox"/> TMJ<br><input type="checkbox"/> Ulcers |
|---|--|---|---|

- (Women) Do you suspect that you are pregnant?  Yes  No Due Date: \_\_\_\_\_
- Do you have any drug allergies or have you ever had an adverse reaction to any medication?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No Name of Physician: \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_
- Are you taking medication at this time?  Yes  No Please list all medication:  
 \_\_\_\_\_  
 \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
 If yes, please explain: \_\_\_\_\_

## Patient Dental History

- Date of Last Dental Visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_ Dentist's name \_\_\_\_\_
  - Have you ever reacted adversely to dental treatment?  Yes  No  
 If yes, please explain: \_\_\_\_\_
  - Do you have dental anxiety or fear?  Yes  No  
 If yes, please explain so that we may make your visit more comfortable: \_\_\_\_\_
- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Do you have jaw pain or headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Does your jaw pop or click? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Do your gums bleed or hurt? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Have you ever had orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> | <ul style="list-style-type: none"> <li>• Does food get caught in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Have any teeth been lost or removed? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Have you ever had gum treatment or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Are your teeth sensitive to: <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> sweets <input type="checkbox"/> pressure</li> <li>• What is your immediate dental concern? _____</li> </ul> |
|---|--|

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

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## Responsible Party

The following is for:  the patient  the patient's spouse  the patient's parent or guardian  the person responsible for payment

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insured's Information

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Name of Carrier: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Name of person or office referring you to our practice \_\_\_\_\_

Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

## Consent for Services and Release of Information

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of information concerning my health care, advice and treatment provided when necessary for referral to other dental providers for specialty treatment.

I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may be less than the actual bill for services.

I understand that I am financially responsible for payment in full of all accounts.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

As a patient, parent or guardian, I acknowledge that I have received a copy of Family Dentistry's *Notice of Privacy Practices*.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**For office use only:** Attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign the acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prohibited obtaining the acknowledgement
- Other \_\_\_\_\_