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:

☐ Allergies
- ☐ Codeine
- ☐ Penicillin
- ☐ Aspirin
- ☐ Latex

☐ Acid Reflux
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Pressure
- ☐ High
- ☐ Low

☐ Cancer
☐ Circulatory Problems
☐ Diabetes
☐ Dizziness / Fainting
☐ Epilepsy / Seizures
☐ Excessive Bleeding
☐ Glaucoma
☐ Habits
- ☐ Alcohol
- ☐ Drugs
- ☐ Smoking / Tobacco

☐ Hay Fever
☐ Headaches
☐ Heart Disease / Attack

☐ Heart Murmur
☐ Hepatitis
- ☐ A
- ☐ B
- ☐ C
- ☐ Unknown

☐ HIV Positive / Aids
☐ Jaundice
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sickle Cell / Trait
☐ Sinus Problems
☐ Stomach Problems
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid Condition
☐ TMJ
☐ 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: ______________________
- Do you clench or grind your teeth? ☐ Yes ☐ No
- Do you have jaw pain or headaches? ☐ Yes ☐ No
- Does your jaw pop or click? ☐ Yes ☐ No
- Do your gums bleed or hurt? ☐ Yes ☐ No
- Have you ever had orthodontic treatment? ☐ Yes ☐ No
- Does food get caught in your teeth? ☐ Yes ☐ No
- Have any teeth been lost or removed? ☐ Yes ☐ No
- Have your ever had gum treatment or surgery? ☐ Yes ☐ No
- Are your teeth sensitive to: ☐ hot ☐ cold ☐ sweets ☐ pressure
- What is your immediate dental concern? ______________________

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.

______________________________________ Date: ______________

Signature of patient, parent or guardian

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.

______________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________ Date: __________ Relationship to Patient: ______________
Signature of responsible party

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***.

______________________ Date: ______________ Relationship to Patient: ____________
Signature of patient, parent or guardian

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______________________