

We are pleased to welcome you to our office. Please take a few moments to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name: _____
Last First MI (Preferred)
Birthdate: _____ SS# _____ DL# _____ Gender: [] M [] F Married: [] Y [] N
Work Phone: _____ Cell Phone: _____ Email: _____

If patient is under 18 years, please also complete the following:

Guarantor Name: _____
Last First MI (Preferred)
Birthdate: _____ SS# _____ DL# _____ Gender: [] M [] F Married: [] Y [] N
Work Phone: _____ Cell Phone: _____ Email: _____
Preferred contact method: [] Home phone [] Wk Phone [] Cell Phone [] Email
Student status if dependent over 19 (for insurance): [] Non-student [] Full-time [] Part-time
How did you hear about us?(Please be specific so we can thank them!)

ADDRESS AND HOME PHONE

Check box if same for entire family []
Address: _____
Address 2: _____
City: _____ State: _____ Zip: _____
Home Phone: _____

INSURANCE POLICY 1

Patient relationship to subscriber: [] Self [] Spouse [] Child
Subscriber Name: _____ Subscriber ID: _____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group Number: _____
*Please present insurance card to receptionist.

INSURANCE POLICY 2

Patient relationship to subscriber: [] Self [] Spouse [] Child
Subscriber Name: _____ Subscriber ID: _____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group Number: _____
*Please present insurance card to receptionist.

Comments: _____

FINANCIAL AGREEMENT

For my convenience, this office may release information to my insurance and receive payments directly from them. If sent to collections, I agree to pay a \$30 collection fee and all related fees and court costs. Every effort will be made to collect payments from my insurance. But if they do not pay as expected, I am responsible. Treatment plans and clinical circumstances may change. I will be financially responsible for the actual treatment completed. I acknowledge that I will be charged a \$25 cancellation fee if cancelling an appointment with less than 24 hrs notice.

MEDICAL HISTORY

Name of Medical Doctor: _____

Doctor State/City: _____

Emergency Contact: _____

Emergency Phone Number: _____

List medications you are now taking:

Check which of the following you are allergic to:

- None Penicillin
- Aspirin Sulfa Drugs
- Codeine
- Metals
- Anesthetics

Check Any Medical Conditions You Have Had:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease/Stroke | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia/Leukemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Hives/Skin Rash | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Fever Blister/Herpes | <input type="checkbox"/> HPV | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Blood Clot Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Dry Mouth/Sjogren | <input type="checkbox"/> Kidney/Bladder Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pacemaker | | | |

Do you use tobacco? If so, what kind and how much? _____

Have you ever had to pre-medicate for a procedure? _____

Do you have any unusual reactions to dental injections? _____

Are you pregnant or have any reason to believe you may be? Yes No

Do you take any blood thinners? _____

List any surgeries or hospital stays : _____

- | | | | |
|--|--|--------------------------------------|--|
| Do you take vitamin supplements? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you take weight loss supplements? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you purchase primarily organic foods? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you take work out supplements? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you take health replacement shakes? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you drink energy drinks? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you wish your smile was prettier? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you have any missing teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you have crooked teeth? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you have any dental pain? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

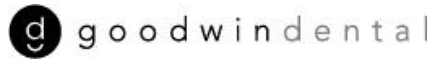
Reason for today's visit: _____

By signing below I certify that all of the above information is true to the best of my knowledge.

Name of Patient/Guardian (printed) _____

Signature _____

Date _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office’s Notice of Privacy Practices.
Name of patient if under 18 years of age.

_____ Parent Name (printed)

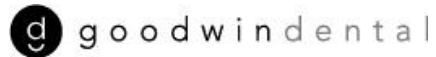
_____ Signature of Parent (if under 18 years of age)

_____ Date

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)



**MEDICAL INFORMATION RELEASE FORM
(HIPPA RELEASE FORM)**

RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

I authorize the release of information including the diagnosis, records; to examination rendered to me and claims information. This information may be release to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call: My home My work My cell phone number

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

Other _____

The best time to reach me is (day) _____ between (time) _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____