goodwindental

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: _____

goodwindental

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
- ❑ Aspirin
- ❑ Codeine
- ❑ Metals
- ❑ Anesthetics
- ❑ Penicillin
- ❑ Sulfa Drugs

Check Any Medical Conditions You Have Had:

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

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?	❑YES ❑NO	Do you take weight loss supplements?	❑YES ❑NO
Do you purchase primarily organic foods?	❑YES ❑NO	Do you take work out supplements?	❑YES ❑NO
Do you take health replacement shakes?	❑YES ❑NO	Do you drink energy drinks?	❑YES ❑NO
Do you wish your smile was prettier?	❑YES ❑NO	Do you have any missing teeth?	❑YES ❑NO
Do you have crooked teeth?	❑YES ❑NO	Do you have any dental pain?	❑YES ❑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

goodwindental

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)
  _____

goodwindental

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: _____