Patient Information

Patient Name: ____ Preferred: _________________________

Home Phone: ____________________ Cell: _____________________ Work: _________________ Ext: ________

Address: ____ Social Security: _____________________________

City: ____ State: _________________ Zip: ____________________

Birth Date: _________________________ E-mail Address: ____

Gender: _____ Male _____Female Family Status: _____Married _____Single _____Child _____Other

Whom may we thank for referring you to our practice? ____

Emergency Contact : ____ Phone :________________________

Employment Information

Employer: ____ Occupation:_____________________________

Spouse or Parent Information if patient is a child

The following is for: _____the patient's spouse **OR** _____the parent or person responsible for payment

Name: _______________________________ Birth Date: ______________ Social Security___________________

Home Phone: ____________________ Cell: _____________________ Work: __________________ Ext: ________

Employer: ____ Occupation: ____________________________

Health Information

_____Allergies	_____Blood Thinner	_____Heart Disease	_____Infectious Diseases
__________________	_____Cancer	_____Heart Murmur	_____AIDS/HIV
_____Codeine	_____Radiation Treatment	_____Pacemaker	_____Hepatitis / Type_______
_____Penicillin	_____Diabetes	_____Rheumatic Fever	_____Tuberculosis
_____Latex	_____Epilepsy	_____Stroke	_____Venereal Disease
_____Anemia	_____ Excessive Bleeding	_____High Blood Pressure	_____Mental/Nervous Disorders
_____Artificial Joints	______Acid Reflux	_____Kidney Disease	_____Respiratory Problems
_____Asthma	_____Head Injuries	_____Liver Disease	_____Thyroid
			_____Other_______________________

Do you smoke or use chewing tobacco? __________ **Please be sure to notify us if you are pregnant.** _________

Have you ever had any complications following dental care? _____ Yes _____No

If yes, please explain: ____

Have you been admitted to the hospital or needed emergency care in the last two years? _____ Yes ____No

If yes, please explain: ____

Name of Physician: ____Phone:______________

Are you under the care of a physician now? _____ Yes _____No

If yes, please explain: ____

List your current daily medications: ____

Preferred Pharmacy: ____

Do you have any health problems that we need to be aware of? _____ Yes _____No

If yes, please explain: ____

Dental Insurance Information

Primary

Name of Insured: _______________________________ Insured's Birth date: _________

Insured's Employer: __________________________________Phone:________________

ID#__________________________________ Group #_____________________________

Insurance Plan Name: ____

Insurance Plan Address: ____

Secondary

Name of Insured: _____________________________ Insured's Birth date: ___________

Insured's Employer: __________________________________Phone:________________

ID#________________________________ Group #_______________________________

Insurance Plan Name: ____

Insurance Plan Address: ____

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.

All emergency services must be paid for at the time of service.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance claim form and will credit any collection to the patient's account. However, this office will not render services on the assumption that our charges will be paid by an insurance company.

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: ____Date: ___________________