

### ABOUT YOU

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Email \_\_\_\_\_  
Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_

### IN CASE OF EMERGENCY, PLEASE CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_

### PERSON RESPONSIBLE FOR YOUR BILL

Name \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### DENTAL INSURANCE

Dental Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Coverage Holder \_\_\_\_\_ Their Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Their Employer \_\_\_\_\_ Their Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### MEDICAL HISTORY

Are you currently under the care of a physician? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Name of Physician \_\_\_\_\_ Physician Phone # \_\_\_\_\_

Preferred Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Are you currently taking any medications including non-prescription? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please list all medications and dosage \_\_\_\_\_

Do you require antibiotics prior to dental treatment? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had any total joint replacements? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, where? (ie: knee, hip, shoulder, etc) \_\_\_\_\_ Replacement Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Have you ever had an abnormal response to dental treatment or dental anesthetic? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Are you taking or previously taken bisphosphonate medications? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

(i.e. Actonel, Bonivia, Fosomax, Zometa)

Are you allergic to any of the following?

Penicillin	YES _____ NO _____	Doxycycline	YES _____ NO _____	Are you allergic to any other drugs or substances?	YES _____ NO _____
Sulfa Drugs	YES _____ NO _____	Tetracycline	YES _____ NO _____	If yes, please list	_____
Latex	YES _____ NO _____	Erythromycin	YES _____ NO _____		_____
Aspirin	YES _____ NO _____	Codeine	YES _____ NO _____		_____

MEDICAL HISTORY

Do you have or have you ever had any of the following diseases or medical conditions?

Heart Attack?..... YES \_\_\_\_\_ NO \_\_\_\_\_, if yes, when? \_\_\_\_\_

Stroke?..... YES \_\_\_\_\_ NO \_\_\_\_\_, if yes, when? \_\_\_\_\_

Hepatitis?..... YES \_\_\_\_\_ NO \_\_\_\_\_, if yes, when? \_\_\_\_\_

- Acid Reflux / GERD ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Alcohol Dependency..... YES \_\_\_\_\_ NO \_\_\_\_\_
Allergies/Seasonal ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Anemia..... YES \_\_\_\_\_ NO \_\_\_\_\_
Arrhythmia ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Arthritis..... YES \_\_\_\_\_ NO \_\_\_\_\_
Artificial Heart Valve ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Asthma..... YES \_\_\_\_\_ NO \_\_\_\_\_
Bleeding Disorder ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Bronchitis ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Cancer ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Depression/Anxiety ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Diabetes..... YES \_\_\_\_\_ NO \_\_\_\_\_
Drug Dependency..... YES \_\_\_\_\_ NO \_\_\_\_\_
Emphysema/COPD ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Glaucoma ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Headaches/Migraines ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Heart Defect..... YES \_\_\_\_\_ NO \_\_\_\_\_

- Heart Disease ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Heart Murmur ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Heart Surgery ..... YES \_\_\_\_\_ NO \_\_\_\_\_
High Blood Pressure ..... YES \_\_\_\_\_ NO \_\_\_\_\_
HIV / AIDS..... YES \_\_\_\_\_ NO \_\_\_\_\_
Kidney Disease ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Liver Disease..... YES \_\_\_\_\_ NO \_\_\_\_\_
Low Blood Pressure ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Lupus..... YES \_\_\_\_\_ NO \_\_\_\_\_
Osteoporosis ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Pacemaker / Defibrillator..... YES \_\_\_\_\_ NO \_\_\_\_\_
Rheumatic Fever ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Seizures ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Sinus Problems ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Sleep Apnea ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Thyroid Problems ..... YES \_\_\_\_\_ NO \_\_\_\_\_
Tuberculosis..... YES \_\_\_\_\_ NO \_\_\_\_\_
Ulcers / Colitis ..... YES \_\_\_\_\_ NO \_\_\_\_\_

WOMEN ONLY

Are you pregnant or breast feeding?...YES \_\_\_\_\_ NO \_\_\_\_\_ Due Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you using Birth Control?.....YES \_\_\_\_\_ NO \_\_\_\_\_

DISCLAIMER

Although unlikely, there are certain inherent risks and potentially dangerous outcomes in any treatment plan or procedure. I understand the following potential outcomes of treatment: pain, swelling, infection, numbness, bleeding, damage to teeth, crowns or bridges, sinus communication and instrument separation. I understand that I am financially responsible for all fees including any collection costs, attorney costs, and or any court costs associated with the payment of fee for service. I certify that I have read and understand the above. I will not hold my dentist, or any other member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party

Date

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand this information can and will be used to: 1.) Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly. 2.) Obtain payment from third party payers for my health care services. 3.) Conduct normal health care operations such as quality assessment and improvement activities. I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices, and that I may contact this office to obtain a current copy of the practices. I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does not agree then it is bound to abide by such restrictions.

Patient Name

Relationship to Patient

Signature

Date