



Date \_\_\_\_\_

**1. Patient Information**

First Name: \_\_\_\_\_ Last: \_\_\_\_\_ M.I.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_ Circle: Male or Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you find out about us (name if referral patient)? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

What is your reason for dental visit?  
\_\_\_\_\_

Would you like to receive email correspondences? **YES OR NO**

Would you like to receive SMS text messages for appointment and check up reminders? **YES OR NO**

What type of Insurance? (Circle One) **MEDICAID CHIP INSURANCE CASH**

**2. If patient is under 18 years old, please complete responsible party (Parent/Guardian) Information.**

First Name: \_\_\_\_\_ Last: \_\_\_\_\_ M.I.: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

**HIPAA PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

As a healthcare provider, we may receive substance use disorder records, which are protected under title 42 of the Code of Federal Regulations Part 2. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This HIPAA Consent was signed by: \_\_\_\_\_  
**Signature of patient/responsible party** **Print name**

**FINANCIAL AGREEMENT**

- \* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- \* If sent to collections, I agree to pay a **\$30 collection fee**, all related fees and court costs.
- \* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- \* Treatment plans may change, and I will be responsible for the work actually done.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_.
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_.
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_.
- Are you taking any medication, pills or drugs?  Yes  No If yes, please explain: \_\_\_\_\_.
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes, please explain: \_\_\_\_\_.
- Have you ever taken Fosamax, Boniva Actonel or Any other medications containing bisphosphonates?  Yes  No If yes, please explain: \_\_\_\_\_.
- Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_.
- Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_.

### Woman: Are you.....

- Pregnant/Trying to get Pregnant?       Nursing?       Taking oral contraceptives?

### Are you allergic to any of the following?

- Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Sulfa Drugs     Local Anesthetics
- Other ?    If yes, please explain: \_\_\_\_\_.

- Do you use controlled substances?  Yes  No If yes, please explain: \_\_\_\_\_.

### Do you have, or have you had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina (CHEST PAINS)      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_.

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_