Patient Information

First name: _____ Last Name:_____

Preferred name: _____ Middle initial: _____

Date of birth:_____ SSN:_____-_____-_____

Gender: ☐ male ☐ female Marital Status: _____

How did you find our office?

☐ Google/internet search
☐ Friend:_____ (please list name)
☐ Family member:_____(please list name)
☐ Social Media
☐ Other:_____

Home number: (_____)_____-_____ Cell number: (_____)_____-_____

Email address: _____

Mailing Address: _____
(street address) (apt./unit #)

_____
(City) (State) (Zip code)

Emergency contact: _____
(First name) (Last name)

Emergency contact Relationship: _____

Emergency contact phone number: (____) - _____ - _____

Employer_____ Employer Phone_____

Dental Insurance_____ Group #_____

Insurance ID number_____

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DMD

HIPAA Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No
May we leave a message on your answering machine? ☐ Yes ☐ No
May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

Print name: _____

Signature: _____ Date:_____/_____/_____

Financial Agreement

I understand that fees and estimated copays are payable at the time of service and I also agree to assign insurance benefits to this office to apply to the remaining balance.

Signature: _____ Date:_____/_____/_____

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Health History

Primary Care Physician Information

Are you under the care of a primary care physician?
☐ Yes ☐ No

Primary Physician:_____ Phone: (_____)_____-_____

Most recent check-up:
☐ Less than 1 year ago ☐ More than 1 year ago ☐ More than 5 years ago

Medication information

Please list all medications you are currently taking. If you are unsure of any names/dosages, please bring an updated medication list to your next visit.

Name of Medication	Dosage (mg)	Frequency	Reason for taking medication

☐ Check if you are unsure of any medications and please bring an updated list to your next visit

Surgical History

Have you ever had any surgeries? ☐ Yes ☐ No

If yes, please include additional information regarding your surgeries below:

Type of surgery	Date of surgery

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Medical conditions

Do you have a history of any of the following conditions? If yes, please list specifics/details

Allergies	☐ Yes	☐ No	_____
Cardiovascular disease	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Thyroid disease	☐ Yes	☐ No	_____
GI diseases/disorders	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Sleep Disorders	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Bleeding disorders	☐ Yes	☐ No	_____
Sinus problems	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Hepatitis	☐ Yes	☐ No	_____
Any other conditions	☐ Yes	☐ No	_____

Are you pregnant? ☐ Yes ☐ No ☐ N/A
If yes, how many weeks? _____

Pre-medication

Do you require antibiotic pre-medication prior to dental treatment? ☐ Yes ☐ No
If yes, what is the reason? _____

Dental History

Do you have dry mouth or notice low salivary flow?	☐ Yes	☐ No
Do your gums bleed when you brush your teeth?	☐ Yes	☐ No
Have you ever received treatment for periodontal disease?	☐ Yes	☐ No
Are you satisfied with the appearance of your teeth?	☐ Yes	☐ No
Do you wake up with tired or sore jaw muscles?	☐ Yes	☐ No
Do you notice clicking in your jaw when you open/close?	☐ Yes	☐ No
Are you satisfied with the appearance of your teeth?	☐ Yes	☐ No
Have you ever fainted in a dental office?	☐ Yes	☐ No
Have you ever had braces or clear aligners?	☐ Yes	☐ No

To the best of my knowledge, the above information is accurate.

Signature:_____ Date:_____/_____/_____