



WELCOME!

So we may provide you with the best possible care and get to know you better, please complete the personal information, medical and dental history forms. Please be assured that ALL information is confidential.

Date: _____

Name of Patient _____

Date of Birth ____/____/____

Social Security # ____ - ____ - ____ Sex: M or F

Address of Primary Residence _____

City _____ State _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____

In Case of Emergency, Contact _____ /Phone # _____

How were you referred to our office? _____

Responsible Party/Billing Information

Name: _____

Billing Address _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information

Do you have dental insurance? Yes or No Please provide your insurance card.

Insured's Name: _____ Employer's Name: _____

Insured's Social Security # or Id#: _____ Date of Birth: _____

Insurance Company: _____ Group#: _____



Patient Medical History

General Questions. This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

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

- | | | | |
|-----------------------------------|--------|---|--------|
| AIDS/HIV _____ | Yes No | Hepatitis _____ | Yes No |
| Allergy to Latex _____ | Yes No | High Blood Pressure _____ | Yes No |
| Anemia _____ | Yes No | Irregular Heart Beat _____ | Yes No |
| Angina Pectoris/Chest Pain _____ | Yes No | Kidney Disease _____ | Yes No |
| Arthritis _____ | Yes No | Liver Disease _____ | Yes No |
| Artificial Joints _____ | Yes No | Mitral Valve Prolapse _____ | Yes No |
| Asthma _____ | Yes No | Organ Transplant _____ | Yes No |
| Bleeding Disorder _____ | Yes No | Pacemaker/Implanted Defibrillator _____ | Yes No |
| Cancer _____ | Yes No | Prosthetic (artificial) Heart Valve _____ | Yes No |
| Chemotherapy _____ | Yes No | Psychiatric Treatment _____ | Yes No |
| Colitis/Intestinal Problems _____ | Yes No | Radiation Therapy _____ | Yes No |
| Diabetes _____ | Yes No | Renal Dialysis _____ | Yes No |
| Emphysema _____ | Yes No | Rheumatic Fever _____ | Yes No |
| Epilepsy/Seizures _____ | Yes No | Sexually Transmitted Disease _____ | Yes No |
| Heart Attack _____ | Yes No | Stomach Ulcer _____ | Yes No |
| Heart Disease _____ | Yes No | Stroke _____ | Yes No |
| Heart or Bypass Surgery _____ | Yes No | Thyroid Disease _____ | Yes No |
| Heart Murmur _____ | Yes No | Tuberculosis (TB) _____ | Yes No |

Have you ever taken an appetite suppressant? (Such as Fen-Phen) _____

Do you smoke tobacco? _____ How much do you smoke? _____ How long have you smoked? _____

Do you use alcohol? _____ How many drinks per week? _____

Do you use recreational drugs? _____ What type? _____ Last recreational drug use? _____

For Women Only: Do you believe you are presently pregnant? _____ Are you currently taking Birth Control Pills? _____

Please list any allergies:

Please list any medications:

Doctors notes:

Consent for Treatment

I, hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Patient's signature: _____ Date: _____

Guarantor's signature _____ Date: _____



DENTAL HISTORY AND SMILE ANALYSIS

When was your last dental appointment? _____

When was your last dental cleaning? _____ Dental x-rays? _____

Are you having any problems at this time? _____

Are your teeth sensitive to any of the following? (Please circle all that apply) Heat Cold Sweets Biting or Chewing

Have you ever been told that you have gum disease? _____

Have you ever experienced: (Please circle)

Discomfort, popping, clicking or locking of your jaw? Yes No

Pain upon chewing, opening wide or yawning? Yes No

Grinding or clenching your teeth? Yes No

Frequent headaches, neck or shoulder aches? Yes No

Loose teeth or changes in your bite? Yes No

Do you have a night guard? Yes No

On a scale from 1-10 (10 being best) how would you rate your:

Dental Health: _____ Your Smile: _____

Is there anything that concerns you about your smile? (color, spaces, chips, unsightly crowns or Restorations, etc.) _____

Do you have any concerns about your old fillings or restorations? _____

If possible, would you like whiter teeth? _____

If you could wave a magic wand over your smile, what would you like to see?

With modern technology and clinical expertise, we can create dramatic improvements in one's smile. Would you like to discuss the possible treatment options that address your concerns? Yes No (Circle One)

Name _____ Date _____



HIPAA Privacy Rights Request Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial) _____
Social Security # or Patient ID

Street address _____
City State ZIP Code

Primary phone number _____
Other phone number E-mail address

Type of Request

- Access/copy Amendment Restriction
 Confidential communication Accounting of disclosures Complaint

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]

Please list [Company Name] staff members that were contacted regarding this matter:

Name Date Name Date

Signature _____ Date _____

For Administrative Use Only: Date received _____

Action taken _____
_____ Date _____

Action taken _____
_____ Date _____

Privacy Official signature _____ Date _____

[Attach additional documentation, if applicable.]