Patient, Pharmacy and Insurance Information

Patient Information

Prefix: ______ First Name: ____________________ Middle Name: ____________________ Last Name: ____________________

Suffix: ______

Street: ____________________________________ Zip: _______ City: ______________________ State: ______ Country: _______________

Preferred Phone #: _________________________ Is this a mobile number? Yes ☐ No ☐

Email Address: ____________________________________

Date of Birth: __________ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _________________________ Emergency Phone #: _________________________

Primary Language: ☐ English ☐ Spanish ☐ Other: _______

Responsible Party

First Name: ____________________ Middle Name: ____________________ Last Name: ____________________

Street: ____________________________________ Zip: _______ City: ______________________ State: ______ Country: _______________

Date of Birth: __________ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: ____ Date: _________________

Preferred Pharmacy

Name: ____________________________________ Phone Number: _________________________

Street: ____________________________________ Zip: _______ City: ______________________ State: ______

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: ____________________ Middle Name: ____________________ Last Name: ____________________

Employer Name: _________________________ Insurance Company: _________________________

Ins Phone Number: _________________________

Subscriber ID/Policy Number: _________________________ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _________________________

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: ____________________ Middle Name: ____________________ Last Name: ____________________

Employer Name: _________________________ Insurance Company: _________________________

Ins Phone Number: _________________________

Subscriber ID/Policy Number: _________________________ Group/Contract Number: _________________________ Date of Birth: __________

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _________________________

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: ____________

Height: _______ ft _______ in Weight: _______ Patient Date of Birth: _________

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

Primary Physician's Name: ____________ Physician's Phone Number: ____________

Date of Last Physical:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _________

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

☐ No ☐ Yes How Long? ____________

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Other: ____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ **None**

Check any conditions that apply to you:

☐ **None**

☐ Alcoholism

☐ Allergies or Hives

☐ Anemia

☐ Arthritis

☐ Artificial Joint/Pins

Type: ____________

Age: ____________

☐ Aspirin Therapy

☐ Asthma

☐ Blood Thinners

☐ Blood Transfusion

☐ Breathing Problems

☐ Cancer

Type: ____________

☐ Chemotherapy

☐ Coumadin Therapy

☐ Dementia

☐ Diabetes

Type: ____________

☐ Dialysis

☐ Drug Addiction

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting/Dizziness

☐ Hearing Impairment

☐ Heart Murmur

☐ Heart Surgery

Date: ____________

☐ Heart Trouble

Type: ____________

☐ Hepatitis

Type: ____________

☐ High Blood Pressure

☐ HIV

☐ Kidney Disease

☐ Liver Disease

☐ Low Blood Pressure

☐ Lung Disease/COPD

☐ Lupus

☐ Mitral Valve Prolapse

☐ Mobility Impairment

☐ NON-DENTAL Implants

Type: ____________

☐ Organ Transplants

Type: ____________

☐ Pace Maker

☐ Psychiatric Care

☐ Radiation Therapy

☐ Radiosurgery

☐ Rheumatic Fever

☐ Seizures

☐ Sexually Transmitted Disease

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Thyroid Disease

☐ Tuberculosis(TB)

☐ Ulcers

☐ Visual Impairment

☐ Other Disease/Illness

Type: ____________

Dental History

Date of Last Dental Visit:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: __________

Date of Last Dental X-ray:
☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: __________

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No
Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? ________

Are you currently wearing Dentures? ☐ Yes ☐ No
Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years
Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores
☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: __________

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: ____ Date: _______________

Dr's Signature/Medical History Review: ____ Date: _______________

6 MONTH UPDATE

Patient's Signature: ____ Date: _______________

Dr's Signature/Medical History Review: ____ Date: _______________

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: ______________________________ Date: ____________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: ______________________________

Relationship to the Patient: ______________________________

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date: ____________________ End Date: ____________________

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: ______________________________ Date: ____________

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: ______________________________ Date: ____________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: ______________________________ Date: ____________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)