Last Name____________________, **First Name**____________________

Middle Initial _____ **NickName** ________________ **Male** _____ **Female** _____

SSN _____-_____-_____ **Date Of Birth** _____/_____/_____ **Marital Status** ______

Address ____

City ____________________ **State** _______ **Zip** __________

Home Phone _____-________ **Cell Phone** _____-________ **Work Phone** ____-________

Email Address____

Emergency Contact Name ____________________ **Phone** _____-________

How did you hear about us ______________________________

DENTAL INSURANCE INFORMATION

Insurance Name ____________________ **Phone** ______________

Policy/MemberNumber ____________________ **Group Number** __________

Name of Policy Holder ____________________ **Date Of Birth**__________

SSN ____________________ **Employer** ____________________

RESPONSIBLE PARTY Self ________ **Other** ____________________

I certify that my responses are true and correct to the best of my knowledge and will notify Alpha Dental should any of the above information change.

I acknowledge full responsibility for the payment of service and agree to pay for them in full at or before completion, unless other specific arrangements have been made.

______________________________ ____________________

SIGNATURE **DATE**

Time 9:51 AM

Alpha Dental PLLC

Date 3/31/2016

ALPHA DENTAL MEDICAL HISTORY FORM

Patient Name: Birth Date: Date Created:

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

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes

Do you take, or have you taken, Phen-Fen or Redux, Fosamax, Bonivia, Actonel or any medication ◯ Yes ◯ No If yes

Do you use tobacco? If so, how much do you use? ◯ Yes ◯ No If yes

Do your gums bleed when you brush? ◯ Yes ◯ No

Are your teeth sensitive to cold, hot, sweets or pressure? ◯ Yes ◯ No If yes

Do you have any current dental problems? ◯ Yes ◯ No If yes

Do you wear any removable dental appliance? ◯ Yes ◯ No If yes

Women: 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

Do you use controlled substances? ◯ Yes ◯ No If yes

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

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

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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:

X

Date:__________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

ALPHA DENTAL
9897 LAKE WORTH ROAD, SUITE 108
LAKE WORTH, FL 33467

Acknowledgement

I, ________________________________, hereby acknowledge that I have received and reviewed a copy of ALPHA DENTAL'S *HIPAA Notice of Privacy Practices*.

I understand that ALPHA DENTAL'S *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of ALPHA DENTAL'S revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about ALPHA DENTAL'S *HIPAA Notice of Privacy Practices*, I may contact Christine at 561-855-4914.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that ALPHA DENTAL will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding ALPHA DENTAL'S privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Christine, noted above, for assistance.

______________________________	______________________________
Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

ALPHA DENTAL made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, ALPHA DENTAL was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on ______________________, 20______.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):____

Date Received	By	Patient ID