NEW PATIENT MEDICAL HISTORY

Patient Information

(Please Print)

☐ Miss ☐ Ms. ☐ Mrs. ☑ Mr. ☐ Dr.

Name _____ Birth date _____ Age _____ S.S. No. _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # (____) _____ Cell Phone # (____) _____

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work Phone # (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # (____) _____

E-mail Address _____

Responsible Party

Name of person responsible for this account? _____

Relationship _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # (____) _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birth date _____ Social Security # _____

Date Employed _____

Name of employer _____ Work Phone # (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do you have additional insurance? ☐ No ☐ Yes If yes, please complete the following:

Name of Insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone # (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

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 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 the 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. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

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 a 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).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:_____

Signature - Patient or Representative

Relationship to patient (if other than patient):_____

Date:_____

Dental History

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last cleaning _____ Date of last dental x-rays _____

How often do you brush? _____ How often do you floss? _____

Do you like the way your smile looks? ☐ Yes ☐ No If not, what would you change? _____

Please check any of the following conditions that apply to you:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

Medical History

Physician _____ Date of last visit _____

Are you in good health? ___ _____

Please list all medications you are currently taking: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Do you have a history of the following?

☐ HIV/AIDS	☐ Blood Disease	☐ Heart Problems	☐ Respiratory Disease
☐ Allergy to Anesthetics	☐ Blood Transfusion	☐ Hemophilia	☐ Rheumatic Fever
☐ Allergy to Antibiotics	☐ Cancer	☐ Hepatitis	☐ Scarlet Fever
☐ Allergy to Banana, Chestnut, Kiwi	☐ Chemical Dependency	☐ High Blood Pressure	☐ Shortness of breath
☐ Allergy to Latex	☐ Circulatory Problems	☐ Stroke	☐ Thyroid problems
☐ Allergy to Penicillin	☐ Cough, Persistent	☐ Jaw Pain	☐ Tobacco Habit
☐ Anemia	☐ Cough up blood	☐ Kidney Disease	☐ Tonsillitis
☐ Arthritis, Rheumatism	☐ Diabetes	☐ Liver Disease	☐ Tuberculosis
☐ Artificial Heart Valves	☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Artificial Joints	☐ Fainting	☐ Pacemaker	☐ Venereal Disease
☐ Asthma	☐ Headaches	☐ Psychiatric Care	☐ Other _____
☐ Back Problems	☐ Heart Murmur	☐ Radiation Treatment	

*If None of the above please initial here:_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of all services rendered and that payments are due on the day of my visit. I understand that there is a fee of $25 for returned checks and a finance charge of $20 per month for bills that are outstanding for more than 30 days. I understand that there is a $50 per hour fee assessed if I do not give 24 hour notice of cancellation for scheduled appointments. I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date