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:_____

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 sections.