



Personal Information

Name: Last			First			Middle		
Address: Street or P.O. Box #			City		State		Zip code	
						Phone Number: Home: Work:		
Pager#:		Cell Phone:			Email Address:			
Age: Yrs.	Birth Date: Mo. Day Year			Birthplace:			<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated	
Social Security No: (if child, parents)				Driver's License No:				
Occupation:		Employer:			How long employed?		Address & Phone No:	
Person responsible for bill:		Age:	Address:			Relationship:	Social Security No:	
							Driver's License No:	
Occupation:			Employer:				How long Employed?	
Employer Address & Phone No:								

Insurance Information

Insured Person's Full Name			Date of Birth			
Social Security Number		Relationship to Patient			Work Phone	
Insurance Company Name		Group or Union Name			Group or Local Numbers	
Employer's Name			Full Address of Employer			

Getting to Know You

<p>1. Why did you select our practice? _____</p> <p>2. Whom may we thank for referring you? _____</p> <p>3. Is another member of your family or relative a patient in our practice? _____</p> <p>4. Person to contact for emergency: _____ Phone: _____</p>	<p>5. When was your last dental visit? _____</p> <p>6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____</p> <p>7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants</p>
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Payment Alternatives

<p><b>Please check appropriate box:</b></p> <p><input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.</p> <p><input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.</p> <p><input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.</p>	<p>This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.</p> <p><input type="checkbox"/> 4. MasterCard, Visa, Discover and American Express</p> <p><input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.</p>
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I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_ © Jameson 2008

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
- Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_

Patient Name _____
Patient Account No. _____

# DENTAL HISTORY

Medical Alert _____
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*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

- |   |     |    |
|---|-----|----|
| Hot or cold?  | Yes | No |
| Sweets?   | Yes | No |
| Biting or Chewing?  | Yes | No |
| Have you noticed any mouth odors or bad tastes?                       | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

- |   |     |    |
|---|-----|----|
| Clench or grind your teeth while awake or asleep?                               | Yes | No |
| Bite your lips or cheeks regularly?   | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep?  | Yes | No |
| Have tired jaws, especially in the morning?                                     | Yes | No |
| Snore or have any other sleeping disorders?                                     | Yes | No |
| Smoke/chew tobacco or use other tobacco products?                               | Yes | No |

**Have you ever had:**

- |   |     |    |
|---|-----|----|
| Orthodontic treatment?                  | Yes | No |
| Oral Surgery?                           | Yes | No |
| Periodontal treatment?                  | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard?            | Yes | No |
| A serious injury to the mouth or head?  | Yes | No |
- If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

- |  |     |    |
|--|-----|----|
| Clicking or popping of the jaw?                    | Yes | No |
| Pain? (joint, ear, side of face)                   | Yes | No |
| Difficulty in opening or closing the mouth?        | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches?            | Yes | No |
| Sore muscles (neck, shoulders)?                    | Yes | No |

Are you satisfied with your teeth's appearance? Yes No  
 Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No  
 If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No  
 If yes, please describe \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No  
 If yes, please describe \_\_\_\_\_



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# HIPAA

## Administrative Simplification: Privacy, Security, Transactions NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT ("HIPAA")

HIPAA stands for the Health Insurance, Portability and Accountability Act of 1996, Public Law 104-191. The HIPAA privacy regulation requires "covered entities" to protect the privacy of individuals' health information.

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

I, \_\_\_\_\_, have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of health information to carry out treatment, payment activities and health care operations.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

If there is anyone you would like us to speak with about your medical records or financials, please list them below.

_____	_____
_____	_____
_____	_____