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Confidential Medical & Dental History Form

Name: _____ Date of Birth: ___/___/___ Sex: __M__F

Social Security #: ____-___-____ Marital Status: Married___ Single ___ Other_____

Address: _____City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Address: _____

Email: _____ Insurance: Yes ____ No ____

Insurance Information On Person Carrying Insurance

Name of Insured: _____ Dental Insurance Company: _____

Date of Birth: ___/___/___ Social Security #: ____-___-____ Home Phone: _____

Employer Name: _____ Work Phone #: _____

I understand that insurance coverage is estimated. You, the patient, are responsible for all amounts not covered by your insurance carrier. Year-to-Date used benefits and remaining deductible amount are not affected until the procedure is completed and therefore, are not used in the determination of benefits.

Medical History

Circle conditions that apply:

Anemia	Arthritis	Asthma	Blood Disease
Blood Transfusion	Cancer/Tumor	Chest Pain	Diabetes
Drug Allergies	Epilepsy	Fainting	Glaucoma
Heart Murmur	Heart Trouble	Hepatitis/Jaundice	H/L Blood Pressure
HIV/AIDS	Kidney/Bladder	Liver Disease	Lung Disease
Mental Disorders	Prolonged Bleeding	Prosthetic Joint	Radiation Treatment
Rheumatic Fever	Shortness of Breath	Sinus Trouble	Stroke
Thyroid Disease	Tuberculosis		

Allergies: _____

Women Only: Are you or could you be pregnant? Yes____ No ____

If yes, How many months? _____

Are you breast-feeding? Yes ____ No ____

Date of last physical exam: ___/___/___

Are you currently under a physicians care? Yes __ No__ Physicians Name: _____

Have you been a patient in a hospital or had any serious illness? Yes ___ No ___

Signature: _____ Date: _____

Medication List

Please list all of the medications you are currently taking and the dosage and frequency you take the medications. *If you do not have this information with you please mail/email the information to us.

MEDICATION	DOSAGE	FREQUENCY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. Our notice provides a description of out treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to your protected health information. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting Dr. John Walker, D.D.S.

Right to revoke: you will have the right to revoke the consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you, if you revoke this consent.

I, _____, have had 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 for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care.

Signature: _____ Date: _____