PATIENT INFORMATION

Date ______________

Patient Name______________________________ Preferred Phone# __________________ Home, Cell, Work

Preferred Name (if appl.)___________________ Alternate Phone #__________________ Home, Cell, Work

Street Address____

City________________________________ State_________ Zip _________________

Patient's Date of Birth____________________ Sex: M / F Patient's SSN__________________

Marital Status: [Please circle] Single / Married / Divorced / Widowed / Religious Affiliate /Other

Employer________________________________ Work Phone#_________________________

Street Address____

City________________________________ State_________ Zip _________________

INSURANCE INFORMATION

Do you have dental insurance? Yes / No Insurance Carrier _______________________

Policyholder ID#______________________________ Policyholder SSN _____________________

If the Policyholder is different from the patient listed above, please complete:

Policyholder Name: ____________________________ Policyholder Date of Birth________________

REFERRAL INFORMATION

Referred by_____________________________ Family Dentist_______________________________

Physician_______________________________ Last Seen/Reason____________________________

DENTAL HISTORY

1. What is your biggest concern about your gums, mouth, or teeth?

2. When was your last visit to your family dentist and the nature of the treatment?

3. Have you had periodontal treatment before? If yes, when and where?

4. How often and when is the last time your teeth were cleaned?

Check the following conditions if they apply to you:					
☐	Swollen or bleeding gums	☐	Bad breath or mouth odors	☐	Bad tastes
☐	Painful gums or teeth	☐	Sensitivity to hot, cold or sweets	☐	Clench or grinding of teeth
☐	Loose teeth	☐	Increasing spaces between teeth	☐	Other

5. How would you feel if you had to lose your teeth?

IMPORTANT: Have you ever been treated for thin bones (**Osteoporosis, Osteopenia**)? *IF YES,* please check:			
ACTONEL___	**FOSAMAX**___	**BONIVA**___	**ZOMETA**___
SKEUD___	**OSTAC**___	**BONEFOS**___	**DIDRONEL**___

MEDICAL HISTORY

Place check in the YES or NO column	YES	NO
1. Are you allergic to any medications? ______________________________	___	___
2. Have you had any serious illness, operation, or hospitalization in the past?	___	___
3. Has there been a change in your health in the last 2 years?	___	___
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment?	___	___
5. Are you presently under the care of a physician?	___	___
6. Do you smoke or use tobacco products? How much?_______ How long?______	___	___
7. Do you drink alcoholic beverages?	___	___

8. HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	___	___	Angina	___	___	Aids or related Complex	___	___
Heart Murmurs	___	___	Heart Attack	___	___	Blood disorders	___	___
Prolapsed Mitral Valve	___	___	Pacemaker	___	___	Joint Implants	___	___
Rheumatic Fever	___	___	Emphysema	___	___	Nervous Disorders	___	___
Heart Problems	___	___	Asthma	___	___	Epilepsy / Seizures	___	___
Heart Bypass Surgery	___	___	Dialysis	___	___	Steroids Last 2 Years	___	___
Kidney Disease	___	___	Tuberculosis	___	___	Radiation / Chemo	___	___
Chemical Dependency Treatment	___	___	Stroke	___	___	H.I.V. Positive	___	___
Hepatitis / Liver Disease	___	___	Diabetes	___	___			
Oral Surgery Complications	___	___	Arthritis	___	___	**Women Only:**		
Thyroid Disorders	___	___	Headaches	___	___	Pregnant	___	___
Bleeding Problems	___	___	Cancer	___	___	Breast Feeding	___	___

9. List **ANY** drugs or medicines that you are currently taking.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
__________________	______________________________	_______________
__________________	______________________________	_______________
__________________	______________________________	_______________
__________________	______________________________	_______________

PATIENT SIGNATURE______________________________________ Date___________

TO BE FILLED IN BY DOCTOR

MEDICAL HISTORY REVIEWED / UPDATED ON: _______ BY_______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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