

# Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form  
completely in ink. If you have any questions or need assistance, please ask us -  
we will be happy to help.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated  
If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Is this person currently a patient in our office? ☐ Yes ☐ No  
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.  
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please



# Patient Medical History

Physician _____	Office Phone _____	Date of Last Exam _____	
		Yes      No	
1. Are you under medical treatment now? .....	<input type="checkbox"/> <input type="checkbox"/>	10. Are you wearing contact lenses? .....	<input type="checkbox"/> <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/> <input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	
If yes, please explain _____		Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/> <input type="checkbox"/>
		Penicillin or any other Antibiotics .....	<input type="checkbox"/> <input type="checkbox"/>
		Sulfa Drugs .....	<input type="checkbox"/> <input type="checkbox"/>
		Barbiturates .....	<input type="checkbox"/> <input type="checkbox"/>
		Sedatives .....	<input type="checkbox"/> <input type="checkbox"/>
		Iodine .....	<input type="checkbox"/> <input type="checkbox"/>
		Aspirin .....	<input type="checkbox"/> <input type="checkbox"/>
		Any Metals (e.g. nickel, mercury, etc.) .....	<input type="checkbox"/> <input type="checkbox"/>
		Latex Rubber .....	<input type="checkbox"/> <input type="checkbox"/>
		Other (please list) _____	
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/> <input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ...	<input type="checkbox"/> <input type="checkbox"/>
If yes, what medication(s) are you taking? _____		13. Women Only:	
4. Have you ever taken Fen-Phen/Redux? .....	<input type="checkbox"/> <input type="checkbox"/>	a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....	<input type="checkbox"/> <input type="checkbox"/>	b) Are you nursing? .....	<input type="checkbox"/> <input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? .....	<input type="checkbox"/> <input type="checkbox"/>	c) Are you taking oral contraceptives? .....	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use tobacco? .....	<input type="checkbox"/> <input type="checkbox"/>		
8. Do you use controlled substances? .....	<input type="checkbox"/> <input type="checkbox"/>		
9. Do you have or have you had any of the following?			
	Yes      No	Yes      No	Yes      No
High Blood Pressure .....	<input type="checkbox"/> <input type="checkbox"/>	Heart Disease .....	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/> <input type="checkbox"/>	Cardiac Pacemaker .....	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur .....	<input type="checkbox"/> <input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/> <input type="checkbox"/>	Angina .....	<input type="checkbox"/> <input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/> <input type="checkbox"/>	Frequently Tired .....	<input type="checkbox"/> <input type="checkbox"/>
Asthma .....	<input type="checkbox"/> <input type="checkbox"/>	Anemia .....	<input type="checkbox"/> <input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/> <input type="checkbox"/>	Emphysema .....	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/> <input type="checkbox"/>	Cancer .....	<input type="checkbox"/> <input type="checkbox"/>
Leukemia .....	<input type="checkbox"/> <input type="checkbox"/>	Arthritis .....	<input type="checkbox"/> <input type="checkbox"/>
Diabetes .....	<input type="checkbox"/> <input type="checkbox"/>	Joint Replacement or Implant .....	<input type="checkbox"/> <input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis / Jaundice .....	<input type="checkbox"/> <input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/> <input type="checkbox"/>	Sexually Transmitted Disease .....	<input type="checkbox"/> <input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/> <input type="checkbox"/>	Stomach Troubles / Ulcers .....	<input type="checkbox"/> <input type="checkbox"/>
		Chest Pains .....	<input type="checkbox"/> <input type="checkbox"/>
		Easily Winded .....	<input type="checkbox"/> <input type="checkbox"/>
		Stroke .....	<input type="checkbox"/> <input type="checkbox"/>
		Hay Fever / Allergies .....	<input type="checkbox"/> <input type="checkbox"/>
		Tuberculosis .....	<input type="checkbox"/> <input type="checkbox"/>
		Radiation Therapy .....	<input type="checkbox"/> <input type="checkbox"/>
		Glaucoma .....	<input type="checkbox"/> <input type="checkbox"/>
		Recent Weight Loss .....	<input type="checkbox"/> <input type="checkbox"/>
		Liver Disease .....	<input type="checkbox"/> <input type="checkbox"/>
		Heart Trouble .....	<input type="checkbox"/> <input type="checkbox"/>
		Respiratory Problems .....	<input type="checkbox"/> <input type="checkbox"/>
		Mitral Valve Prolapse .....	<input type="checkbox"/> <input type="checkbox"/>
		Other .....	<input type="checkbox"/> <input type="checkbox"/>

# Patient Dental History

Name of Previous Dentist and Location _____	Date of Last Exam _____		
		Yes      No	Yes      No
1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/> <input type="checkbox"/>	8. Do you have frequent headaches? .....	<input type="checkbox"/> <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/> <input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/> <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/> <input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/> <input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/> <input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/> <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/> <input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/> <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/> <input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?		14. Do you wear dentures or partials? .....	<input type="checkbox"/> <input type="checkbox"/>
Clicking .....	<input type="checkbox"/> <input type="checkbox"/>	If yes, date of placement _____	
Pain (joint, ear, side of face) .....	<input type="checkbox"/> <input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/> <input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/> <input type="checkbox"/>		

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X  
Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments _____
Signature _____ Date _____



{NAME OF PRACTICE}

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

## SECTION B: 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 this Consent. Our Notice provides a description of our 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. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

**Right to Revoke:** You will have the right to revoke this 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.

## SIGNATURE

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 to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**