AMANDA SCARBOROUGH, D.D.S.

Date:_____

PATIENT INFORMATION

Legal Name_____ _____ Preferred Name_____
Last Name First Name Middle Initial

Address_____City_____ State_____ Zip Code_____

Soc. Sec.#_____ Home Phone#_____Cell Phone# _____

Sex ☐ M ☐ F Age_____ Birthday _____ Name of Guardian if under 18_____

Patient /Guardian Employed By_____ Occupation_____ Business Phone#_____

Who do we see in your household?_____ Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____ Phone#_____ Date of Last Visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ **Artificial Heart Valve**	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ **Artificial Joints**	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ **Mitral Valve Prolapse**	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ **Heart Murmur**	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Disease	☐ Psychiatric Care	☐ Tuberculosis
☐ **Chemotherapy**	Describe_____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Problems	☐ Other_____

MEDICATIONS (List medications you are currently taking)

1._____ 4._____ 7._____

2._____ 5._____ 8. _____

3._____ 6. _____ 9._____

MEDICATION ALLERGIES

In case of emergency who should be notified?_____ Phone #_____

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____ Date of last dental visit_____

Are you happy with the way your teeth look? □ Yes □ No Describe_____
Would you like your teeth to look whiter or lighter? □Yes □ No

Check (√) if you have or have had problems with any of the following:

□ Bad Breath	□ Food Collection between teeth	□ Loose teeth or broken filling	□ Sensitivity to hot
□ Bleeding gums	□ Grinding teeth	□ Periodontal treatment	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Growths or sores in your mouth	□ Sensitivity to cold	□ Sensitivity when biting

How often do you floss?_____ How often do you brush?_____

AUTHORIZATION

I certify that the above information is correct to the best of my knowledge.

I understand that I am financially responsible for all charges whether or not paid by insurance. I will use my best efforts to notify Hill County Dental of any change in my information in a timely manner. I agree that I will be responsible for all remaining charges that my insurance company fails to provide.

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Please notify us at least 24 hours prior to your appointment time if you are unable to keep your appointment. We reserve the right to discontinue patients that have three missed or broken appointments.

Signature: _____Date:_____

HIPPA-RECEIPT OF PRIVACY PRACTICES

HIPPA is the Health Insurance Portability and Accountability Act, which was created in 1996 to regulate how health information about you may be used and disclosed. This act was created to protect patients' confidentiality. All health care providers are required to have a signature on file that documents that you have had the opportunity to read the privacy practices.

I acknowledge that I have read and may receive a copy at my request of the Notice of Privacy Practices for Hill family Dental.
Patient's Signature: _____
If patient is a minor, patient's parent or guardian must sign.

Staff will complete this section if patient's signature not obtained-
*****Our office made a good faith effort to obtain Acknowledgment of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason: □Language Barriers □Patient refused to sign □Other _____