Patient Information

Full Name of Patient _____ *Preferred Name* _____

☐ *M* ☐ *F* ☐ *Child* ☐ *Single* ☐ *Married* ☐ *Divorced*

Address _____ *City* _____ *State* _____ *Zip* _____

Home Number _____ *Cell Phone* _____ *Work Phone* _____

Date of Birth _____ *SSN* _____ *Spouse's SSN* _____

Email _____

Name of Your Dental Insurance Provider _____

Group No. _____ *ID No.* _____

Employed By _____ *Occupation* _____

Business Phone _____ *City* _____ *State* _____ *Zip* _____

Spouse Employed By _____ *Occupation* _____

Business Phone _____ *City* _____ *State* _____ *Zip* _____

We will use and communicate your **HEALTH INFORMATION** only for the purpose of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Medical History

(Please check YES or NO and fill-in as necessary.)

	YES	NO
Are you in good health now?	☐	☐
Are you under the care of a physician?	☐	☐
If so, what is the condition being treated?	☐	☐
Physician's Name _____		
Phone # _____		
Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
(Women) Are you pregnant?	☐	☐
If so, give due date _____		
Do you use tobacco in any form?	☐	☐
If yes, how much _____		
Do you use alcoholic beverages (3+ drinks per day)?	☐	☐

Do you have or have you ever had any of the following:	YES	NO
Tire easily	☐	☐
Frequent nosebleeds	☐	☐
Headaches	☐	☐
Bruise easily	☐	☐
Prolonged bleeding	☐	☐
Cancer	☐	☐
Chest pain/discomfort	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
Radiation therapy	☐	☐
Tumors or growths	☐	☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, or Guardian _____ **Date** _____

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US.

Medical Information (continued)

Name of Patient _____ *Date of Birth* _____

Do you have, or have you had, any of the following?

☐ Yes	☐ No	*Aids/HIV Positive*
☐ Yes	☐ No	*Alzheimer's Disease*
☐ Yes	☐ No	*Anaphylaxis*
☐ Yes	☐ No	*Anemia*
☐ Yes	☐ No	*Angina*
☐ Yes	☐ No	*Arthritis/Gout*
☐ Yes	☐ No	*Artificial Heart Valve*
☐ Yes	☐ No	*Artificial Joint*
☐ Yes	☐ No	*Asthma*
☐ Yes	☐ No	*Blood Disease*
☐ Yes	☐ No	*Blood Transfusion*
☐ Yes	☐ No	*Breathing Problems*
☐ Yes	☐ No	*Bruise Easily*
☐ Yes	☐ No	*Cancer*
☐ Yes	☐ No	*Chemotherapy*
☐ Yes	☐ No	*Chest Pains*
☐ Yes	☐ No	*Cold Sores, Fever Blisters*
☐ Yes	☐ No	*Congenital Heart Disorder*
☐ Yes	☐ No	*Convulsions*
☐ Yes	☐ No	*Cortisone Medicine*
☐ Yes	☐ No	*Diabetes*
☐ Yes	☐ No	*Drug Addiction*
☐ Yes	☐ No	*Easily Winded*
☐ Yes	☐ No	*Emphysema*
☐ Yes	☐ No	*Epilepsy or Seizures*
☐ Yes	☐ No	*Excessive Bleeding*
☐ Yes	☐ No	*Excessive Thirst*
☐ Yes	☐ No	*Fainting Spells / Dizziness*
☐ Yes	☐ No	*Frequent Cough*
☐ Yes	☐ No	*Frequent Diarrhea*
☐ Yes	☐ No	*Frequent Headaches*
☐ Yes	☐ No	*Genital Herpes*
☐ Yes	☐ No	*Glaucoma*
☐ Yes	☐ No	*Hay Fever*
☐ Yes	☐ No	*Heart Attack / Failure*
☐ Yes	☐ No	*Heart Murmur*
☐ Yes	☐ No	*Heart Pacemaker*
☐ Yes	☐ No	*Heart Trouble / Disease*
☐ Yes	☐ No	*Hemophilia*
☐ Yes	☐ No	*Hepatitis A*
☐ Yes	☐ No	*Hepatitis B or C*
☐ Yes	☐ No	*Herpes*
☐ Yes	☐ No	*High Blood Pressure*
☐ Yes	☐ No	*High Cholesterol*
☐ Yes	☐ No	*Hives or Rash*
☐ Yes	☐ No	*Hypoglycemia*
☐ Yes	☐ No	*Irregular Heartbeat*
☐ Yes	☐ No	*Kidney Problems*
☐ Yes	☐ No	*Leukemia*
☐ Yes	☐ No	*Liver Disease*
☐ Yes	☐ No	*Low Blood Pressure*
☐ Yes	☐ No	*Lung Disease*
☐ Yes	☐ No	*Lupus*
☐ Yes	☐ No	*Mitral Valve Prolapse*
☐ Yes	☐ No	*Osteoporosis*
☐ Yes	☐ No	*Pain In Jaw Joints*
☐ Yes	☐ No	*Parathyroid Disease*
☐ Yes	☐ No	*Psychiatric Care*
☐ Yes	☐ No	*Radiation Treatment*
☐ Yes	☐ No	*Recent Weight Loss*
☐ Yes	☐ No	*Renal Dialysis*
☐ Yes	☐ No	*Rheumatic Fever*
☐ Yes	☐ No	*Shingles*
☐ Yes	☐ No	*Sickle Cell Disease*
☐ Yes	☐ No	*Sinus Trouble*
☐ Yes	☐ No	*Spina Bifida*
☐ Yes	☐ No	*Stomach / Intestinal Disease*
☐ Yes	☐ No	*Stroke*
☐ Yes	☐ No	*Swelling of Limbs*
☐ Yes	☐ No	*Thyroid Disease*
☐ Yes	☐ No	*Tonsillitis*
☐ Yes	☐ No	*Tuberculosis*
☐ Yes	☐ No	*Tumors or Growths*
☐ Yes	☐ No	*Ulcers*
☐ Yes	☐ No	*Venereal Disease*
☐ Yes	☐ No	*Yellow Jaundice*

Have you ever had any serious illness not listed above?

If yes, please explain: _____

_____

Medical Information (continued)

Name of Patient _____ *Date of Birth* _____

Are you taking any medications, pills, oral contraceptives or drugs?

Please list name, dosage, and reason: _____

_____

_____

Are you allergic to any of the following?

☐ *Aspirin* ☐ *Penicillin* ☐ *Codeine* ☐ *Local Anesthetics* ☐ *Acyrlic* ☐ *Metal* ☐ *Latex*

☐ *Sulfa Drugs* ☐ *Others*

If yes, please list and explain: _____

_____

Notice of Privacy Practices

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valued patient.

Signature _____ I HAVE READ THE PRIVACY POLICY.

Values Sheet

Our office is like no other. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your initial visit.

Are you having any areas of concern?

_____

Tell us in your opinion what you think the present state of health of your mouth is.

_____

How healthy do you want us to get your mouth?

☐ *Don't really care.* ☐ *Average.* ☐ *The best it can be.*

What caused you to leave your last dental office?

_____

What would you like to change about your smile?

_____

How did you hear about our office?

_____

What do you already know about our office and what are your expectations?

_____

Has fear ever been an issue for you in a dental office?

_____

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

_____

Has the cost of dental treatment been a concern for you? What can we do to help you with this?

_____

We have the unique ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?

☐ *As a general dentist.* ☐ *As a cosmetic dentist.* ☐ *As a functional dentist.*

At what point do you want to initiate treatment?

☐ *When my tooth hurts or breaks.* ☐ *When something is wrong.* ☐ *When something isn't ideal.*

Is there any additional information you would like us to know?

_____

_____