

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	Do you have or have you ever had any of the following:	YES	NO
Are you in good health now?	<input type="checkbox"/>	<input type="checkbox"/>	Tire easily	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Name _____			Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Phone # _____			Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized or had a serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain _____			Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
If so, give due date _____			Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco in any form?	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much _____			Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcoholic beverages (3+ drinks per day)?	<input type="checkbox"/>	<input type="checkbox"/>			

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?

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

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 Acrylic 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?
