# Welcome To Our Practice

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## *Patient Information* (confidential)

Today's date:_____

Name:_____ Birthdate:_____ Soc. Sec. #:_____

Address:_____ City:_____ State:_____ Zip:_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home phone:_____ Cell phone:_____ Work phone:_____

Patient or Parent's Employer:_____ Address:_____

Spouse or Parent's Name:_____ Employer:_____

How did you hear about us?_____

Person to Contact in Case of Emergency:_____ Phone:_____

## *Responsible Party*

Name of Person Responsible for this Account:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Driver's License #:_____ Birthdate:_____ Email Address:_____

Employer:_____ Work Phone:_____

Is this Person Currently a Patient in Our Office:_____

## *Insurance Information*

Name of Insured:_____ Relationship to Patient:_____

Birthdate:_____ Soc. Sec. #_____ Member ID#_____

Name of Employer:_____ Insurance Company:_____

Insurance Company Phone:_____ Group No:_____

## *Secondary Insurance Information*

*Name of Insured:*_____ *Relationship to Patient:*_____

*Birthdate:*_____ *Soc. Sec. #*_____ *Member ID#*_____

*Name of Employer:*_____ *Insurance Company:*_____

*Insurance Company Phone:*_____ *Group No:*_____

## *Notice of Privacy Practices*

**I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance, and in communicating with other healthcare professionals in the course of my treatment. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support personnel, billing personnel, answering services and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.**
**I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance activities, insurance claims and health care operations. This office retains the right to revise the privacy policy.**

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

*Although we primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive or medications we prescribe. Thank you for answering the following questions.*

**Date of last dental examination: _____ Date of last medical examination: _____**

***Are you allergic to any of the following:*** ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine**
☐ **Local Anesthetics** ☐ **Latex** ☐ **Other** **If yes, please explain: _____**

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***Do you have any of the following conditions:***

| *YES* | *NO* | |
|---|---|---|
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Diabetes Type: _____ |
| ☐ | ☐ | Epilepsy If yes, date of last seizure: _____ |
| ☐ | ☐ | Hepatitis If yes, what type: _____ |
| ☐ | ☐ | Artificial Implants, Heart Stents, Joint Replacements: If yes, what type: _____ Does condition require pre-medication: _____ Are you premedicated today: _____ |
| ☐ | ☐ | Abnormal Heart Condition If yes, explain: _____ |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Any type of Mental Illness or Physical Condition? If yes, what type: _____ |
| ☐ | ☐ | Are you pregnant? If yes, how many months: _____ |
| ☐ | ☐ | Abnormal Bleeding from a Cut? (Hemophilia) _____ |
| ☐ | ☐ | Rheumatic Fever (even as a child) |
| ☐ | ☐ | Cancer If yes, when and what type: _____ |
| ☐ | ☐ | HIV Positive |
| ☐ | ☐ | Are you currently under the care of a physician? Physician Name: _____ Physician Phone Number: _____ |
| ☐ | ☐ | Are you currently taking any medication on a daily basis? **(including Blood Thinners or daily Aspirin)** Please list or use additional paper if necessary: _____ |
| ☐ | ☐ | Have you ever been hospitalized or had a major operation? If yes, please explain: _____ |

**By signing below, I acknowledge that I am over the age of 18 and/or I am the legal parent or guardian.**

_____ _____
**Signature of PATIENT, PARENT or Guardian** **Please Print Name**

**Date: _____**