PATIENT INFORMATION

Name ______________________

Address ______________________

Home Phone ______________________

Work Phone ______________________

Male or Female ______________________

Birthdate ______________________

Social Security Number ______________________

Personal Responsibilities for any balance due on this account.

Name ______________________

Social Security Number ______________________

Driver's License Number ______________________

Employer ______________________

Employer's Address ______________________

INSURANCE INFORMATION

Employee Name ______________________
(if different from patient)

Relationship to patient (Circle One) Self Spouse Dependent

Employee Social Security # ______________________

Employee Birthdate ______________________

Employer ______________________

Employer's Address ______________________

Insurance Company ______________________

Secondary Insurance ______________________

Employee Name ______________________

Relationship to Patient (Circle One) Self Spouse Dependent

Employee Social Security # ______________________

Employee Birthdate ______________________

Employer ______________________

Employer's Address ______________________

Insurance Company ______________________

Name ______________________________

Address ______________________________

City ____________________ Zip Code __________

Date ______________
Date of Birth ______________
Home Phone ______________
Business Phone ______________
Cell Phone ______________
Soc. Sec. No. ______________

PATIENT HEALTH HISTORY

Physician ______________________ Office Phone ______________________

Approximate Date of last physical examination ______________________

		Yes	No		YES	NO
1.	Are you under any medical treatment now?				___	___
2.	Have you had any major operations? If so, what?				___	___
3.	Have you ever had a serious accident involving head injuries?				___	___
4.	Have you had any adverse response to any drugs including penicillin?				___	___
5.	Has a physician ever informed you that you have:			A Heart Ailment/Murmur?	___	___
				Diabetes?	___	___
6.	High Blood Pressure?	___	___	Respiratory Disease?	___	___
7.	Rheumatic Fever?	___	___	Rheumatism or Arthritis?	___	___
8.	Tumors or Growths?	___	___	Any Blood Disease?	___	___
9.	Any Liver Disease?	___	___	Any Kidney Disease?	___	___
10.	Aids?	___	___	Yellow Jaundice or Hepatitis?	___	___
11.	Any Venereal Disease?	___	___	Any Stomach or Intestinal Disease?	___	___
12.	Do you have night sweats accompanied by weight loss or cough?				___	___
13.	Are you on a diet at this time?				___	___
14.	Are you now taking drugs or medication?				___	___
15.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc?				___	___
16.	Are you in general good health at this time?				___	___
17.	Have any wounds healed slowly or presented other complications?				___	___
18.	Are you pregnant?				___	___
19.	Do you have a history of fainting?				___	___
20.	Have you ever had any radiation treatment?				___	___

PATIENT DENTAL HISTORY

		YES	NO
21.	Do you have pain in or near your ears?	___	___
22.	Do you have any unhealed injuries or inflamed areas in or around your mouth?	___	___
23.	Have you experienced any growth or sore spots in your mouth?	___	___
24.	Does any part of your mouth hurt when clenched?	___	___
25.	Have you ever had Novocaine anesthetic?	___	___
26.	Any reactions or allergic symptons to Novocaine?	___	___
27.	Any difficult extractions in the past?	___	___
28.	Prolonged bleeding following extractions in the past?	___	___
29.	Trench mouth?	___	___
30.	Do your gums bleed?	___	___
31.	Have you ever had instruction on the correct method of brushing your teeth?	___	___
32.	Have you ever had instructions on the care of your gums?	___	___
33.	Do you chew on only one side of your mouth? If so, why?	___	___
34.	Do you at present time have any dental complaints?	___	___
35.	Do you habitually clench your teeth during the night or day?	___	___
36.	When was your last full mouth X-RAY taken? ______________ Where? ______________________		
37.	Any part of your mouth sore to pressure or irritants (cold, sweets, etc.)?	___	___
	If so locate ______________________________		

Signature ______________________________________

By initialing this, I acknowledge that I have reviewed this history and have made the necessary changes and dated for verification.

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April 1, 2003

Due to recent changes in the law governing privacy issues, dental offices will not be allowed to use your Social Security number in any way without your written permission. We also will not release any personal, financial, or medical information contained in any patient records without permission from the patient, parent, or guardian.

Generally, when an insurance claim in submitted, the contract number is the subscriber's Social Security number and must be on the claim. Your Social Security number, personal, financial, or medical information may also be contained on records used to collect a debt should collection procedures through a collection agency or Small Claims Court becomes necessary. These would be the only reasons that a patient's information would ever be released by our office, with the following exceptions: It may be necessary for us to make disclosures of your information in connection with your treatment. We may take a referral to another dentist or health-care professional, provide a specimen to a laboratory for testing or otherwise made disclosure of your information in connection with providing or coordinating your care. You may request that all Social Security information be deleted from your records here--however, payment in full would be required on dates of services. Any insurance claims would then need to be submitted by the subscriber/patient.

Full HIPAA information is posted in our waiting room. If you have any questions regarding this information, please feel free to ask.

Does our office have permission to use your Social Security, personal, financial, or medical information as indicated above?

Yes _____ No_____

Do you wish to have Social Security information deleted from our records?

Yes _____ No_____

Thank you for your cooperation.

___________________________________ ______________
Signature (parent or guardian, if minor) Date