First Name: _____ Last Name: _____

Middle Initial: _____ Preferred Name: _____Date of Birth: _____/_____/_____

Address: _____ City, State, Zip: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Gender: ☐Male ☐ Female ☐Other

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Social Security: _____ Email: _____

Emergency Contact: _____ Contact Phone: _____

Employer: _____General purpose for your visit: _____

How did you hear about us? (Check one): ☐Friend/Family ☐ TV ☐ Drive-by ☐ News Paper/mail

☐Google/Bing ☐ Billboard ☐Phone book ☐ Facebook/Instagram ☐Other _____

If a friend or family member referred you, whom may we thank?: _____

* Please Continue This Form Only if You Have Insurance *

Primary insurance information

Insurance Company: _____

Policy Holder Name: _____ Social Security: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Employer: _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other _____

Secondary insurance information

Insurance Company: _____

Policy Holder Name: _____ Social Security: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Employer: _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other _____

Patient's Printed Name: _____ Medical History

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body of course. Therefore, health problems that you may have, or substances that you may be ingesting are very likely to have an important interrelationship with the dental services you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes ☐ No ☐ If yes, please explain: _____

Do you have sleep apnea or snoring? Yes ☐ No ☐ If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, please explain: _____

Have you ever had a problem with tooth extractions of any kind? Yes ☐ No ☐ If yes, please explain: _____

Have you ever had a serious head/neck injury or head/neck radiation? Yes ☐ No ☐ If Yes, please explain: _____

Are you taking any medications, health supplements or controlled substances? Yes ☐ No ☐ If yes, please explain: _____

Have you ever taken or are you currently taking Phen-Fen or Redux (prescribed for weight loss usually)? Yes ☐ No ☐ If yes, please explain: _____

Have you ever taken or are you currently taking Fosamax, Boniva, Actonel, Reclast, Zometa, Prolia, or any other medications called bisphosphonates (prescribed for osteoporosis usually)? Yes ☐ No ☐ If yes, please explain: _____

Have you ever taken or are you currently taking blood thinners including but not limited to aspirin, Coumadin or plavix? Yes ☐ No ☐ If yes, please explain: _____

Have you ever taken or are you currently taking Selective Serotonin Re-Uptake Inhibitors (SSRIs) for depression or otherwise? Yes ☐ No ☐ If yes, please explain: _____

Do you use tobacco in any form? (smoking/vape, chew, etc)? Yes ☐ No ☐ If yes, please explain: _____

Do you have diabetes or are you on any special diet? Yes ☐ No ☐ If yes, please explain: _____

Do you currently wear a full or partial denture? If yes, please tell us how old it is. Yes ☐ No ☐ If yes, please explain: _____

Women: Are you ☐ Pregnant/trying to get pregnant? ☐ Nursing ☒ Taking oral contraceptives

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Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☒ Codeine ☒ Acrylic ☐ Metals: gold, titanium, mercury ☒ Latex ☐ Sulfa drugs ☐ Local Anesthetics ☒ None ☐ Other_____

Circle Yes or No: Do you have, or have you had any of the following?

AIDS/HIV positive	Y N	Cortisone Medicine	Y N	Pain in jaw joints	Y N	Rheumatism	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	osteoporosis	Y N	Scarlet Fever	Y N
Anaphylaxis	Y N	Drug addiction	Y N	Mitral Valve Prolapse	Y N	Shingles	Y N
Anemia	Y N	Easily winded	Y N	Lung Disease	Y N	Sickle Cell Disease	Y N
Angina	Y N	Emphysema	Y N	Low Blood Pressure	Y N	Sinus Trouble	Y N
Arthritis/Gout	Y N	Epilepsy or Seizures	Y N	Liver Disease	Y N	Stomach/Intestinal disease	Y N
Artificial heart valve	Y N	Excessive Bleeding	Y N	Leukemia	Y N	Stroke	Y N
Artificial Joint	Y N	Excessive Thirst	Y N	Kidney Problems	Y N	Swelling of Limbs	Y N
Asthma	Y N	Fainting spells/Dizziness	Y N	Irregular Heartbeat	Y N	Thyroid Disease	Y N
Blood disease	Y N	Frequent Cough	Y N	Hypoglycemia	Y N	Tonsillitis	Y N
Blood Transfusion	Y N	Frequent Diarrhea	Y N	Hives or Rash	Y N	Tuberculosis	Y N
Breathing Problems	Y N	Frequent Headaches	Y N	High Cholesterol	Y N	Tumors/Growths	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Herpes	Y N	Ulcers	Y N
Cancer	Y N	Glaucoma	Y N	High blood pressure	Y N	Venereal Disease	Y N
Chemotherapy	Y N	Hay Fever	Y N	Hepatitis C	Y N	Yellow Jaundice	Y N
Chest Pains	Y N	Heart attack/Failure	Y N	Hepatitis A or B	Y N		
Cold sores/Fever blisters	Y N	Heart Murmur	Y N	Hemophilia	Y N		
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Renal Dialysis	Y N		
Convulsions	Y N	Heart trouble/Disease	Y N	Rheumatic fever	Y N		

Signature:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND CONSENT / LIMITED AUTHORIZATION &RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipts of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TRATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please **print** name of Patient **Signature** of Patient / Patient's Legal Guardian

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding acknowledgments or consents: _____

_____

We will address you by your first name unless you specify otherwise. If you prefer to be summoned from the reception are by a different name please indicate here:

_____

PLEASE LIST ANY OTHIER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION

(This includes spouses, friends, relatives and any care takers who can have access to this patient's records)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer