COMPLETE DENTAL CARE

Patient Information

Name _____ Preferred Name _____ Home Phone _____ ☐M ☐F

Address _____ City _____ State _____ Zip _____

Email _____ Social Security Number _____ Date of Birth _____

Cell _____ Patient or Parent/Guardian's Employer _____ Work Phone _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Emergency Contact _____ Phone _____

Responsible Party *(If same as patient, skip to the next section)*

Name _____ Relationship to Patient _____ Cell _____

Address _____ City _____ State _____ Zip _____

Email _____ Social Security Number _____ Date of Birth _____

Employer _____ Work Phone _____ Home Phone _____

Insurance Information *(If card(s) is available, skip to the next section)*

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Date of Birth _____

Social Security Number _____

Employer _____

Insurance Company _____

Insurance Phone Number _____

ID/Policy Number _____

Group Number _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Date of Birth _____

Social Security Number _____

Employer _____

Insurance Company _____

Insurance Phone Number _____

ID/Policy Number _____

Group Number _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Have you ever been diagnosed with periodontal disease? _____

What changes would you make to improve your smile? _____

Any tooth problems? _____

HIPAA Privacy Practices

I have read the copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date _____

I give my permission to discuss my dental treatment (including but not limited to: treatment, scheduling, billing, insurance, etc.) with the following: _____

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date _____

COMPLETE DENTAL CARE

Patient Medical History

Physician_____ Office Phone _____ Date of Last Exam_____

1. Are you under medical treatment now?.....☐Yes ☐No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....☐Yes ☐No
   If yes, please explain: _____
   _____
   _____
   _____
3. Have you ever had a serious head/neck injury? ☐Yes ☐No
   If yes, please explain: _____
   _____
   _____
4. Are you taking any medication(s), including non-prescription medicine?.....☐Yes ☐No
   If yes, list medication: _____
   _____
   _____
   _____
5. Have you ever taken Phen-Fen or Redux? ..... ☐Yes ☐No
6. Do you use tobacco? ..... ☐Yes ☐No
7. Do you use controlled substances? ..... ☐Yes ☐No
   If yes, please list: _____
   _____
8. Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? ..... ☐Yes ☐No
9. Women, are you:
   Pregnant/trying to get pregnant? ..... ☐Yes ☐No
   Are you nursing? ..... ☐Yes ☐No
   Are you taking oral contraceptives? ..... ☐Yes ☐No
10. Are you allergic to or have you had any reactions to the following?
    Aspirin..... ☐Yes ☐No
    Barbiturates ..... ☐Yes ☐No
    Codeine..... ☐Yes ☐No
    Iodine..... ☐Yes ☐No
    Latex Rubber..... ☐Yes ☐No
    Local Anesthetics (e.g. Novocaine) ..... ☐Yes ☐No
    Metals (e.g. Nickel, Mercury, etc.)..... ☐Yes ☐No
    Penicillin or any other Antibiotics (please list)... ☐Yes ☐No
    _____
    _____
    Sedatives..... ☐Yes ☐No
    Other (Please List)..... ☐Yes ☐No
    _____
    _____
11. Do you have or have you ever had any of the following?
    AIDS/HIV Infection..... ☐Yes ☐No
    Alzheimer's disease..... ☐Yes ☐No
    Anaphylaxis..... ☐Yes ☐No
    Anemia..... ☐Yes ☐No
    Arthritis/Gout..... ☐Yes ☐No
    Artificial joint..... ☐Yes ☐No
    Asthma..... ☐Yes ☐No
    Blood disease/blood transfusion..... ☐Yes ☐No
    Breathing/respiratory problems..... ☐Yes ☐No
    Bruise easily..... ☐Yes ☐No
    Cancer..... ☐Yes ☐No
    Chemotherapy..... ☐Yes ☐No
    Convulsions..... ☐Yes ☐No
    Diabetes..... ☐Yes ☐No
    Emphysema..... ☐Yes ☐No
    Epilepsy or seizures..... ☐Yes ☐No
    Excessive bleeding..... ☐Yes ☐No
    Fainting spells/dizziness..... ☐Yes ☐No
    Frequent cough..... ☐Yes ☐No
    Heart attack/heart failure..... ☐Yes ☐No
    Heart murmur..... ☐Yes ☐No
    Heart pacemaker..... ☐Yes ☐No
    Heart trouble/heart disease..... ☐Yes ☐No
    High blood pressure..... ☐Yes ☐No
    Kidney problems/kidney disease..... ☐Yes ☐No
    Leukemia..... ☐Yes ☐No
    Liver disease..... ☐Yes ☐No
    Low blood pressure..... ☐Yes ☐No
    Low blood sugar/hypoglycemia..... ☐Yes ☐No
    Mitral valve prolapse..... ☐Yes ☐No
    Osteoporosis..... ☐Yes ☐No
    Psychiatric care..... ☐Yes ☐No
    Radiation treatments..... ☐Yes ☐No
    Rheumatic fever..... ☐Yes ☐No
    Thyroid disease..... ☐Yes ☐No
    Tuberculosis..... ☐Yes ☐No
    Stroke..... ☐Yes ☐No
    Other (please list) _____
    _____
    _____
12. Have you ever been told you need antibiotics prophylaxis prior to receiving dental treatment? ..... ☐Yes ☐No