:

INITIALLY REVIEWED BY:_____
INITIALS
DATE:_____

CONFIDENTIAL MEDICAL HISTORY

PATIENT INFORMATION

Patient Name_____Preferred Name_____Date of Birth_____
Home Phone_____Work Phone_____Cell Phone_____
Home Address_____
E-Mail Address: _____ May we contact you by E-Mail? Y❑ N❑
Social Security #_____Patient's Employer_____
Business Address_____
Name of Spouse_____Person Responsible for Account_____
Emergency Contact: Name_____Phone_____
Referred By_____

INSURANCE INFORMATION

Dental Insurance Company_____Group #_____
Insurance Company Address_____Phone #_____
Insurance Policy Holder_____Employed By_____
Policy Holder Address_____
Policy Holder Date of Birth_____Social Security #_____
Member Phone #_____Member ID #_____

MEDICAL HISTORY

Are you currently under the care of a physician?Y❑ N❑ If yes, what condition(s) are you being treated for? _____
_____
Have you ever been hospitalized or had a major operation?.....Y❑ N❑
Please list any medications (prescription or over-the-counter) you are currently taking_____
_____
Do you use tobacco products? Y❑ N❑ If yes, how many packs/day or cans/day?_____
Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other _____
If yes, please describe reaction_____

Do you currently have, or have you had in the past, any of the following conditions? (Check appropriate boxes below)

AIDS/HIV Positive	Y❑ N❑	Diabetes	Y❑ N❑	High Blood Pressure	Y❑ N❑
Alzheimer's/Dimentia	Y❑ N❑	Drug Addiction	Y❑ N❑	Irregular Heartbeat	Y❑ N❑
Anemia	Y❑ N❑	Eating Disorder	Y❑ N❑	Kidney Problems	Y❑ N❑
Arthritis/Gout	Y❑ N❑	Emphysema	Y❑ N❑	Liver Disease	Y❑ N❑
Artificial Heart Valve	Y❑ N❑	Excessive Bleeding	Y❑ N❑	Osteoporosis	Y❑ N❑
Artificial Joint	Y❑ N❑	Blood Thinner:_____	Y❑ N❑	Pain in Jaw Joints	Y❑ N❑
Premed:_____	Y❑ N❑	Excess Thirst/Dry Mouth	Y❑ N❑	Psychiatric Care	Y❑ N❑
81/325mg Aspirin	Y❑ N❑	Fainting Spells/dizziness	Y❑ N❑	Shingles	Y❑ N❑
Breathing Problem	Y❑ N❑	Frequent Headaches	Y❑ N❑	Stomach/Intestinal Disease	Y❑ N❑
Cancer or Tumors	Y❑ N❑			Stroke	Y❑ N❑
Chest Pains	Y❑ N❑	Hay Fever/Sinus Trouble	Y❑ N❑	Thyroid Disease	Y❑ N❑
Cold Sores/Fever Blisters/Ulcers	Y❑ N❑	Heart Trouble/Disease	Y❑ N❑	Tuberculosis	Y❑ N❑
Convulsions/Epilepsy	Y❑ N❑	Hepatitis A, B, or C	Y❑ N❑	Venereal Disease	Y❑ N❑

Do you have, or have you had in the past, any medical conditions not listed above?.....Y❑ N❑
If yes, please list_____

Women only: Are you…
Pregnant or planning pregnancy? Y❑ N❑ Taking oral contraceptives? Y❑ N❑ Nursing? Y❑ N❑
Chief Dental Complaint:_____
Date of Last Dental Visit:_____ Date of Last Dental Cleaning:_____
Additional Comments:_____
_____

CONSENT FOR TREATMENT:

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetics or premedications that may be advised by the doctor. I understand that I will be responsible for any financial obligation for treatment on myself or the above named person. To the best of my knowledge, the questions on this form have been answered accurately. I understand that it is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Signature of Patient, Parent, or Guardian_____Date_____

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DATE:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain
rights to privacy regarding my protected health information. I understand that this information can and will be
used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of
the uses and disclosures of my health information. I understand that this organization has the right to change its
Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a
current copy of the *Notice of Privacy Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to
carry out treatment, payment or health care operations. I also understand you are not required to agree to my
requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient _____

Signature _____

Date_____

(For Office Use Only)
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date_____ Initials_____ Reason _____
_____