PATIENT INFORMATION

Legal Name ____ Nickname __________________________
First Mid. Initial Last

Mailing Address ____
Street/ P.O. Box Unit # City State Zip

Home Phone__________________________Work Phone____________________________Cell Phone__________________________

Social Security #_______________________________________ Date of Birth______________________ Male _____ Female _____

Check appropriate space: Single____ Married____ Divorced____ Separated____ Widowed____ Domestic Partner____

E-mail

Employer (company name/city) ____

Spouse Name ____ Date of Birth _________________
First Mid. Initial Last

Whom may we thank for referring you? ____

In case of emergency, who should be notified? ____

PRIMARY INSURANCE

Subscriber's Name ____ Relationship to Patient _____________________

Mailing Address (if different from patient) ____
Street/ P.O. Box Unit # City State Zip

Group Name (employer name, "Self", etc.) ____

Social Security Number ________________________ Date of Birth _________________ Day Phone ___________________________

Insurance Co._______________________Subscriber ID# ____Group # _________________

SECONDARY INSURANCE

Is the patient covered by additional insurance YES _____ NO _____ - IF YES, PLEASE COMPLETE THIS SECTION:

Subscriber's Name ____ Relationship to Patient _____________________

Mailing Address (if different from patient) ____
Street/ P.O. Box Unit # City State Zip

Group Name (employer name, "Self", etc.) ____

Social Security Number ________________________ Date of Birth _________________ Day Phone ___________________________

Insurance Co._______________________Subscriber ID# ____Group # _________________

ALL INFORMATION WRITTEN IS TRUE AND COMPLETE. SIGNATURE: ____

IF DENTAL INSURANCE APPLIES: Although this office files insurance claims as a service to our patients, the insurance contract is between the patient & the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any amount not paid by insurance, is entirely the responsibility of the patient. INITIALS: _____________

HIPAA ACKNOWLEDGEMENT AND RECEIPT OF NOTICE

PRINT NAME: ____________________________________ **SIGNATURE: __________________________________DATE: _________**

**YOU MAY REFUSE TO SIGN THIS ACKOWLEDGEMENT. PATIENT REFUSED TO SIGN HIPAA _____

OVER →

MEDICAL HISTORY: Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Are you currently under your doctor's care for a current problem? .... **Yes** **No**
   Reason: ____
   Current medical doctor: ____
2. Have you been hospitalized in the past five years? .... **Yes** **No**
   Reason: ____
3. Are you required to take premeds prior to dental treatment? .... **Yes** **No**
4. Have you received therapy for alcoholism or drug addiction during the past five years? .... **Yes** **No**
5. Have you ever had any **ALLERGIC or ADVERSE REACTIONS to anesthetics**, antibiotics, or other medications? .... **Yes** **No**
6. Have you ever had an **ALLERGIC or ADVERSE REACTION to LATEX**? .... **Yes** **No**
7. Have you ever required a blood transfusion? .... **Yes** **No**
   Please explain: ____
8. Have you ever had surgery and/or radiation for a tumor, growth or other condition? .... **Yes** **No**
9. Do you use tobacco (smoking, snuff, chew)?.. **Yes** **No**
10. Are you taking or scheduled to begin taking either of the medications?
    Alendroate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's disease? .... **Yes** **No**
11. List any medications you are currently taking:

12. **Do you or have you ever had any of the following (please check):**

____ Active tuberculosis
____ Angina pectoris
____ Artificial heart valves
____ Asthma
____ Blood disorders
  ____ Sickle cell disease
  ____ Anemia
  ____ Abnormal bleeding
____ Cancer/chemotherapy
____ Congenital heart defects
____ Diabetes
____ Difficult breathing
____ Emphysema
____ Fever blisters
____ Frequent headaches
____ Hepatitis
____ High blood pressure
____ Joint replacement
  ANY complications: ___________________________
____ HIV/AIDS
____ Kidney problems
____ Liver disease
____ Lung disease
____ Heart murmur of prolapsed valve MVP
____ Pacemaker
____ Psychiatric problems
____ Rheumatic fever
____ Seizures
____ Sinus problems
____ Stroke
____ Thyroid problems
____ Venereal diseases

Women Only - Are you: Pregnant? **Yes** **No** If yes, number of weeks? __________
Taking birth control pills or hormonal replacement? **Yes** **No**
Nursing? **Yes** **No**

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. INITIALS: ______________

PERMISSION FOR ROOT CANAL TREATMENT: I, the undersigned, consent to the performing of any dental procedure of the tooth (teeth) which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Signature of Patient/Legal Guardian: ____ Date: ______________________