Patient Information

Date_____

Name_____ Soc.Sec#_____

Address_____ Home/Cell Ph._____

City_____ State_____ Zip_____

Sex _____ Age_____ Birthday_____

Patient Employed by_____Occupation_____

Whom may we thank for referring you? _____

In case of an emergency who should we notify? _____

Phone Number_____

Primary Insurance

Person Responsible for Account_____

Relation to Patient_____ Birthday_____ SS#_____

Address(if different from patients)_____ Phone_____

City_____ State_____ Zip_____

Insurance Company_____

ID#_____ Group#_____

Method of Payment

Which of the follow methods of payment will you be using (Fees must be paid in full at th completion of treatment)

Method of payments: Cash_____ Check_____Visa_____ MC_____

Medical History

Please complete the follow questions in order 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. Has there been any change in your general health within the past year?
   _____
2. Are you under the care of a physician for current problems? Please List
   _____
3. Have you been hospitalized within the past 5 years?
   _____
4. Are you taking any medications or drugs? If so please list.
   _____
5. Have you received therapy for alcoholism or drug addiction in the past 5 years?
   _____
6. Have you ever had any ALERGIC OR ADVERSE REACTIONS.(anesthetics, antibiotics, latex, or other medications)?
   _____
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?
   _____
8. Have you ever required a blood transfusion?
   _____
9. Have you ever been tested for HIV infection? _____
   Results of test: Date_____
10. Date of last physical exam_____
11. Do you have or have you had any of the following:

- High Blood pressure
- Heart murmur
- Joint prosthesis (Hip, knee, ect.)
- Rheumatic fever or rheumatic heart disease
- Congenital heart disease
- Cardiovascular disease: heart attack, stroke, by-pass
- Asthma
- Fainting spells or seizures
- Cancer
- TMJ
- Sinus trouble
- Thyroid problems
- Diabetes
- Stomach ulcers
- Hepatitis, jaundice,
- Kidney problems
- Epilepsy
- Blood disorder

12. Do you have any disease, condition, or problem not listed above?
    _____
13. Are you required to take pre-meds prior to dental treatment?
    _____
14. Are you pregnant? _____
15. Are you nursing? _____

Permission for Root Canal Treatment- I the undersigned, consent to the performing of any dental procedure of the tooth 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 the office. The permanent (outside) restoration (filling, inlay, crown, ect) will be completed by my regular dentist.

Date: _____ Signature of patient_____

- **All signatures must be by parent or guardian it patient is under the age of 18**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing
We will not be allowed to process your insurance claims.

Date_____

The undersigned acknowledgement receipt of a copy of the currently effective Notice of Privacy Practice for _____. Copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____

Please print your name **Please sign your name**

_____ _____

Legal Representative Description of Authority

Please list any other parties who can have access to your dental information:
(this includes step parents, grandparents, and any care taker who can have access to these records)

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I authorize contact from this office to confirm my dental appointment, treatments, and billing information:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Phone Confirmation
- Text message

I authorize information about my dental health be conveyed

- Message on cell Phone
- Message on home Phone
- Message on work Phone
- Text message

I approve being contacted about special services, events, or new dental information

- Phone message
- Text message
- Email
- U.S Mail