FAMILY AND IMPLANT DENTISTRY

Patient Information:

Full Name_____

Address_____

Home phone_____Work phone_____Cell_____

E-mail address_____Age____DOB_____

Single____Married_____SSN_____

Place of Employment_____Position_____

Extended Information (Spouse or Parents):

Name_____Relationship to Patient_____

Address (if different than above)_____

Home phone_____Work phone_____Cell_____

DOB_____SSN_____

Place of Employment_____Position_____

Insurance Information:

Primary Policyholder_____DOB_____

Name and address of Insurance Company_____

_____

ID number_____Group number_____

Secondary Policyholder (if applicable)_____DOB_____

Name and address of Insurance Company_____

_____

ID number_____Group number_____

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1- Are you in good health? **Yes** **No**

2- Has there been any change in your general health within the past year? **Yes** **No**

3- My last physical examination was on _____

4- Are you now under the care of a physician? **Yes** **No**

If so, what is the condition being treated?_____

_____

5- The name and address of my physician is_____

_____

6- Have you had any serious illnesses or operations? **Yes** **No**

If so, what was the illness or operation_____

_____

7- Do you or have you had any of the following conditions:

Joint replacement surgery **Yes** **No**

Rheumatic fever or rheumatic heart disease **Yes** **No**

Congenital heart lesions **Yes** **No**

Sinus Trouble, asthma or hay fever **Yes** **No**

Hives or skin rash **Yes** **No**

Fainting spells or seizures **Yes** **No**

Arthritis or inflammatory rheumatism (painful joints) **Yes** **No**

Cardiovascular disease (heart trouble, heart attack, stroke, coronary insufficiency, coronary occlusion, arteriosclerosis, high blood pressure, damaged heart valves, value replacement or heart surgery) **Yes** **No**

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Kidney trouble Yes No

Diabetes Yes No

Tuberculosis, persistent cough or cough up blood Yes No

HIV (Aids) Yes No

Hepatitis, jaundice or liver disease Yes No

Other_____

8- Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? Yes No

9- Do you bruise easily; have any blood disorders such as anemia? Yes No

10- Are you taking any of the following?

- **Antibiotics** Yes No
- **Anticoagulants (blood thinners)** Yes No
- **Medications for high blood pressure** Yes No
- **Tranquilizers** Yes No
- **Cortisone (steroids)** Yes No
- **Antihistamines** Yes No
- **Aspirin** Yes No
- **Insulin or similar drugs** Yes No
- **Digitalis or drugs for heart trouble, nitroglycerin** Yes No
- **Other** _____

11- Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, explain_____

12- Are you allergic or have you reacted adversely to

- **Local anesthetics** Yes No
- **Penicillin or other antibiotics** Yes No
- **Barbiturates, sedatives or sleeping pills** Yes No
- **Aspirin** Yes No
- **Iodine** Yes No
- **Codeine or other narcotics** Yes No

Other_____ Yes No

13- Do you have any disease, condition or problems not listed above that you think we should know about? **Yes No**

If so, please explain_____

_____

WOMEN

14- Are you pregnant? **Yes No**

15- Are you nursing? **Yes No**

What is the major result you would like from dental treatment at our office?_____

_____

Are you satisfied with the appearance of your teeth? If not, what change would you like in your appearance?_____

Are you experiencing any discomfort at this time?_____

What prompted you to begin dental treatment at this time and is there a specific time in which you need treatment completed by?

Whom may we thank for referring you_____

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for_____**. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or for the above named, regardless of insurance coverage. Treatment Plans involving extended credit circumstances may have a credit check done on their credit rating.**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:_____

SECTION B: TO THE PATIENT- PLEASE READ CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. A copy or our Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____