PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	❑	❑
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	❑	❑
3. ARE YOU TAKING ANY MEDICATIONS INCLUDING NON-PRESCRIPTION MEDICINE?	❑	❑
IF YES, WHAT MEDICATIONS ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	❑	❑
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS	❑	❑
6. ARE YOU WEARING CONTACT LENSES?	❑	❑

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	LOCAL ANESTHETICS (E.G. NOVACAINE)	❑	❑	BARBITURATES	❑	❑	ASPIRIN
❑	❑	PENICILLIN OR OTHER ANTIBIOTICS	❑	❑	SEDATIVES	❑	❑	OTHER _____
❑	❑	SULFA DRUGS	❑	❑	IODINE			_____

8. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR DO YOU THINK YOU MAY BE PREGNANT?	❑	❑
B) ARE YOU NURSING?	❑	❑
C) ARE YOU TAKING BIRTH CONTROL PILLS?	❑	❑

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	HIGH BLOOD PRESSURE	❑	❑	HEART DISEASE	❑	❑	CHEST PAINS
❑	❑	HEART ATTACK	❑	❑	CARDIAC PACEMAKER	❑	❑	EASILY WINDED
❑	❑	RHEUMATIC FEVER	❑	❑	HEART MURMUR	❑	❑	STROKE
❑	❑	SWOLLEN ANKLES	❑	❑	ANGINA	❑	❑	HAY FEVER/ALLERGIES
❑	❑	FAINTING / SEIZURES	❑	❑	FREQUENTLY TIRED	❑	❑	TUBERCULOSIS
❑	❑	ASTHMA	❑	❑	ANEMIA	❑	❑	RADIATION THERAPY
❑	❑	LOW BLOOD PRESSURE	❑	❑	EMPHYSEMA	❑	❑	GLAUCOMA
❑	❑	EPILEPSY / CONVULSIONS	❑	❑	CANCER	❑	❑	RECENT WEIGHT LOSS
❑	❑	LEUKEMIA	❑	❑	ARTHRITIS	❑	❑	LIVER DISEASE
❑	❑	DIABETES	❑	❑	JOINT REPLACEMENT OR IMPLANT	❑	❑	HEART TROUBLE
❑	❑	KIDNEY DISEASE	❑	❑	HEPATITIS/JAUNDICE	❑	❑	RESPIRATORY PROBLEMS
❑	❑	AIDS OR HIV INFECTIONS	❑	❑	SEXUALLY TRANSMITTED DISEASE	❑	❑	_____
❑	❑	THYROID PROBLEM						_____
			❑	❑	STOMACH TROUBLE / ULCERS			

COMMENTS

_____

_____

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_____

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_____

_____

SIGNATURE DATE

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN EXPECTED FOR SERVICES RENDERED ON MY BEHALF, AND I WILL ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE. I ALSO UNDERSTAND THAT MY CREDIT HISTORY MAY BE RE-VIEWED IF I AM TO BE EXTENDED CREDIT BY THIS OFFICE.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT INFORMATION

CONFIDENTIAL DATE _____

NAME _____ BIRTHDATE _____
FIRST INT LAST

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ PATIENT SOC. SEC. NO. _____

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ HOW LONG? _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This ACKNOWLEDGEMENT *

I,_____ , have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

PATIENT INFORMATION

CONFIDENTIAL DATE _____

NAME _____ BIRTHDATE _____
FIRST INIT LAST

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ PATIENT SOC. SEC. NO. _____

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ HOW LONG? _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____