

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care.

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us… We will be happy to help.

Patient # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#/SIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information** (CONFIDENTIAL)- PLEASE PRINT

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Prov\_\_\_\_\_\_\_\_ Zip/ P.C.\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/ Prov.\_\_\_\_\_\_\_\_ Full Time Part Time

Patient or Parent/Guardian’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Prov.\_\_\_\_\_\_\_ Zip/ P.C.\_\_\_\_\_\_\_\_\_\_

Spouse or Parent/Guardian’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_

**Whom May We Thank for Referring You?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Financial Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/SIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer***. Payment in full is due at each appointment.***

 Cash Personal Check Credit Card: Visa MasterCard American Express  CareCredit

**Insurance Information**

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/SIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Union or Local # \_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estate/ Prov. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Prov.\_\_\_\_\_\_\_ Zip/ P.C.\_\_\_\_\_\_\_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much Have You Used? \_\_\_\_\_\_\_\_\_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_\_\_\_\_\_\_.

*DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:*

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/SIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Union or Local # \_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estate/ Prov. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/ Prov.\_\_\_\_\_\_\_ Zip/ P.C.\_\_\_\_\_\_\_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much Have You Used? \_\_\_\_\_\_\_\_\_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_\_\_\_\_\_\_.

Over Please!

**Patient Medical History**

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_Date of Last Exam \_\_\_\_\_\_ Pharmacy Name & Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

 Yes No

**9**. **Are you allergic to or have you had any reactions to the following?**

 Local Anesthetics (e.g. Novocain)……………………

Penicillin or any other Antibiotics ……………………

Sulfa Drugs …………………………………………...

Barbiturates……………………………………………

Sedatives………………………………………………

Iodine …………………………………………………

Aspirin ………………………………………………..

Any Metals (e.g. nickel, mercury, etc.)……………….

Latex Rubber………………………………………….

Other (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Do you have a persistent cough or throat clearing not**

**associated with a known illness (lasting more than 3 weeks)..**

**11.** **Women Only:**

1. Are you pregnant or think you may be pregnant?...
2. Are you nursing?.....................................................
3. Are you taking oral contraceptives?........................

**1**.Are you under medical treatment now?...............................

**2**. Have you ever been hospitalized for any

surgical operation or serious illness within the last 5 years?..

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**.Are you taking any medication(s) including

non-prescription medicine?....................................................

If yes, what medication(s) are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4**. Have you ever taken **bisphosphonates**?(Fosamax, Actonel, Boniva; IV: Aredia, Zometa)

**5**. Do you use tobacco?...........................................................

**6**. Do you use controlled substances?.....................................

**7**. Do you have any **artificial joints?** (Hip, knee, etc)............

**8**.Do you have or have you had any of the following?

Yes No

Yes No

Yes No

High Blood Pressure……….

Heart Attack……………….

Rheumatic Fever…………..

Swollen Ankles……………

Fainting/Seizures………….

Asthma…………………….

Low Blood Pressure……….

Epilepsy/Convulsions…….

Leukemia………………….

Diabetes……………………

Kidney Diseases…………..

Thyroid Problem ………….

AIDS or HIV Infection…...

Heart Disease……………………

Cardiac Pacemaker……………...

Heart Murmur…………………..

Angina…………………………..

Frequently Tired………………..

Anemia………………………….

Emphysema……………………..

Cancer…………………………..

Arthritis…………………………

**Joint Replacement or Implant**..

Hepatitis/Jaundice………………

Sexually Transmitted Disease….

Stomach Troubles/Ulcers……….

Chest Pains…………………….

Easily Winded………………….

Stroke…………………………..

Hay Fever/Allergies……………

Tuberculosis……………………

Radiation Therapy……………..

Glaucoma………………………

Recent Weight Loss……………

Liver Disease…………………..

Heart Trouble………………….

Respiratory Problems………….

Mitral Valve Prolapse………….

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Dental History**

Name of Previous Dentist and Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

Yes No

**1.**Do your gums bleed while brushing or flossing?.................

**2.**Are your teeth sensitive to hot or cold liquids/foods?.........

**3.**Are your teeth sensitive to sweet or sour liquids/foods?.....

**4.**Do you feel pain to any of your teeth?.................................

**5.**Do you have any sores or lumps in or near your mouth?....

**6.**Have you had any head, neck or jaw injuries?.....................

**7.**Have you ever experienced any of the following

problems in your jaw?

 Clicking…………………………………………..

 Pain (joint, ear, side of face)……………………..

 Difficulty in opening or closing………………….

 Difficulty in chewing…………………………….

**8.**Do you have frequent headaches?........................................

**9.**Do you clench or grind your teeth?.............................

**10.**Have you ever had a **periodontal scaling**

**or “deep cleaning**”?............................................................

**11.**Have you ever had any difficult extractions

in the past?.......................................................................

**12.**Have you ever had any prolonged bleeding

following extractions?.....................................................

**13.**Have you had any orthodontic treatment?................

**14.**Do you wear dentures or partials?.............................

 if yes, Date of placement\_\_\_\_\_\_\_\_\_\_\_\_\_

**15.**Have you ever received oral hygiene instructions

regarding the care of your teeth and gums?....................

**16.**Do you like to smile?..................................................

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of patient (or parent/guardian if minor)*

**Name of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Advanced + Family Dentistry is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.**

**Entity to receive information**

**Initial** each person/entity that you approve to receive information.

\_\_\_\_\_\_\_ Home Voice Mail

\_\_\_\_\_\_\_ Cell Voice Mail

\_\_\_\_\_\_\_ Cell Voice Mail

\_\_\_\_\_\_\_ Give Information to Employer

\_\_\_\_\_\_\_ Give Information to School

\_\_\_\_\_\_\_ Spouse

\_\_\_\_\_\_\_ Parent

\_\_\_\_\_\_\_ Grandparent

\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of information**

**Initial** each that can be given to person/entity on the left in the same section.

\_\_\_\_\_\_\_ Appointment Reminders

\_\_\_\_\_\_\_ Needed Appointments

\_\_\_\_\_\_\_ Treatment Needs/Information

\_\_\_\_\_\_\_ Appointment Absentee Information

\_\_\_\_\_\_\_ Appointment Information

\_\_\_\_\_\_\_ Family Billing Information

\_\_\_\_\_\_\_ Financial Information

\_\_\_\_\_\_\_ Treatment Needs/Information

\_\_\_\_\_\_\_ Transmitting any and all medical, dental, financial, & billing information through the internet and phone lines.

**Rights of the Patient**

I understand that I have the right to revoke this authorization at any time that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending written notification to Advanced and Family Dentistry. I understand that revocation is not in effect in cases where information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. Description of personal representative’s authority and Advanced +Family Dentistry HIPAA Policy was given to me to read or a copy was given to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian or Personal Representative Date