



### Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_



### Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient



### Phone Numbers

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_



### Dental History

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Dental Registration and History



# Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |   |  |                       |  |                                    |  |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head<br>or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
|   |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |

Do you wear contact lenses?  Yes  No

### Women:

Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No



## Medications

List any medications you are currently taking and the correlating diagnosis:

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

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_



## Allergies

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |



## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**As Your Authorization:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

AV Dental  
*(Insert Name of Practice)*

**SECTION A: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

*Include this acknowledgement of receipt in the individual's records.*

**ACKNOWLEDGEMENT OF RECEIPT OF  
PRIVACY PRACTICES NOTICE**