PATIENT INFORMATION AND MEDICAL HISTORY

Date:_____ Home Phone:_____ Email:_____

Patient Name (Last, First, MI, Nickname):_____

Address (Number, Street, City, State, Zip):_____

_____Cell Phone:_____

Gender: M or F Age:_____ DOB:_____/_____/_____ Patient's SSN:_____

Marital Status: Single Married Separated Divorced Widowed

Work Phone:_____ Pharmacy (Name/Phone):_____

Employer (Name/Address):_____

In case of emergency, who should be notified?_____Phone:_____

Primary Dental Insurance:_____ **Secondary** Dental Insurance:_____

Employer Name:_____ Employer Name:_____

Insured Name:_____ Insured Name:_____

Group #:_____ Group #:_____

Member ID #:_____ Member ID:_____

Social Security #:_____ Social Security #:_____

DOB:_____ DOB:_____

Who referred you to our practice?_____

Have you ever had any of the following? (Check all that apply):

___Heart Problems
___High Blood Pressure
___Low Blood Pressure
___Circulatory Problems
___Diabetes
___Cancer
___Radiation Treatment/Chemotherapy
___Nervous Problems
___Psychiatric Care
___Artificial Heart Valves or Joints
___Respiratory Disease
___Epilepsy
___Headaches
___Back problems
___Arthritis
___Recent Weight Loss
___Chronic Diarrhea
___Allergies to Drugs/Medicines
___Allergies to Anesthetics
___General Allergies
___Blood Disease/Hemophilia
___Hepatitis/Jaundice/Liver Disease
___"AIDS" or Other Immunosuppressive Disorder
___Special Diet
___Rheumatic Fever
___Stroke
___Ulcer
___Thyroid Disease
___Venereal Disease
___Chemical Dependency
___Swollen Neck Glands
___Sinus Problems

Are you taking any medication(s) at this time?_____If so, what?_____
_____

_____.

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____If so, what?_____
_____.

Have you ever responded adversely to medical or dental treatment?_____.

Are you currently under the care of a physician? YES / NO Physician Name/Phone_____.

For what condition?_____Date of Last Physical_____.

(Women) Do you suspect that you are pregnant? YES / NO Are you nursing? YES / NO

Is there anything else we should know about your medical history?_____.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold the dental staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:_____ Signature_____.

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Acknowledgement of Review/Receipt of HIPPA Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information, and these rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have the right to review and secure a copy of this office's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA.

I have reviewed (and can receive if desired) a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

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

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

_____