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PATIENT INFORMATION

Name: _____ Prefer to be called: _____ Male or Female
Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birthdate: _____ Email: _____

DENTAL HISTORY

1. Do you use tobacco?	YES	NO
2. Do you consume alcohol?	YES	NO
3. Do you use cocaine or other recreational drugs?	YES	NO
4. Are you using contact lenses?	YES	NO
5. Have you taken any bisphosonates drugs? (ex: actonel, boniva, fosamax)	YES	NO
6. Do you use an automatic toothbrush?	YES	NO
7. Do you wear a nightguard?	YES	NO
8. Is there anything that you would like to change about your smile?	YES	NO
9. Have you had any difficulty or complications with **local** anesthesia?	YES	NO

MEDICATION

( ) NONE
1)
2)
3)
4)
5)
6)
7)

ALLERGIES

( )	Local anesthetic	( )	Codeine	( )	Iodine
( )	Sedatives	( )	Ibuprofen	( )	Red Dye
( )	Penicillin	( )	Latex		
( )	Sulfa Drugs	( )	Other Antibiotic: _____		
( )	Aspirin	( )	Other: _____		

PAST MEDICAL PROCEDURES OR HOSPITAL ADMISSIONS

( ) NONE

_____

_____

ANY FUTURE PLANNED ELECTIVE SURGERIES?

( ) NONE

_____

_____

HIPAA Notice of Privacy Practice

This form does not constitute legal advice an covers only federal, not state, laws.

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge reciept of this notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and have read the contents. I understand that I am giving my consent to use and disclose my health care information to carry out treatment, education, payment activities and health care options.

Printed Name: _____

Signature: _____ Date: _____
(if patient is a minor, parent/guardian signature)

Medical Information Release

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me

□ Parent/Guardian_____
□ Spouse _____
□ Child(ren) _____
□ Other _____

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

□ My Home □ My Work □ My Cell Number _____

If unable to reach me:

□ you may leave a detailed message
□ please leave a message asking me to return your call
□ other: _____
The best time to reach me is (day) _____ between (time) _____

Mark any of the following which you have had or have at present:

CARDIOVASCULAR

( ) Angina/Chest Pains
( ) Congestive Heart Failure
( ) Heart Attack
( ) Heart Disease
( ) Heart Trouble
( ) Elevated Cholesterol
( ) High Blood Pressure
( ) Mitral Valve Prolapse
( ) Past Surgeries
( ) Other _____
( ) Rheumatic Fever
( ) **None for this system**

RESPIRATORY

( ) Asthma
( ) Tuberculosis
( ) Emphysema
( ) Respiratory Problems
( ) Past Surgeries
( ) Other _____
( ) **None for this system**

EYES/EARS/NOSE/THROAT

( ) Glaucoma
( ) Seasonal Allergies
( ) Smoking
( )Current ( )Former
years smoked ____
cigs per day _____

MUSCULOSKELETAL

( ) Arthritis
( ) Rheumatoid Arthritis
( ) Pain
( ) Joint Replacement
( ) Other _____
( ) **None for this system**

GASTROINTESTINAL

( ) Liver Disease
( ) Anorexia
( ) Bulimia
( ) Crohn's Disease
( ) GERD/esophageal relfux
( ) Heart Burn
( ) Hepatitis
( ) Past Surgeries
( ) Other _____
( ) **None for this system**

REPRODUCTIVE

( ) Sexually Trans Disease
( ) Are you pregnant?
( ) Are you nursing?
( ) Are you taking birth control?

ONCOLOGY/HEMATOLOGY

( ) Currently undergoing treatment
( ) In Remission
List any diagnosis and/or treatment:

_____

_____

NEUROLOGICAL

( ) Alzheimer's
( ) Seizures
( ) Fainting
( ) Epilepsy/Convulsions
( ) Past Surgeries
( ) Stroke
( ) Other _____
( ) **None for this system**

ENDOCRINOLOGY

( ) Diabetes Type I
( ) Diabetes Type II A1C:
( ) Hypothyroidism
( ) Hyperthyroidism
( ) Past Surgeries
( ) Other _____
( ) **None of this system**

Signature:_____ Date: _____