



Jason Knag DDS

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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 4)
 1) 5)
 2) 6)
 3) 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 and 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 receipt 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 and

- 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 Murmur
- Heart Trouble
- Elevated Cholesterol
- High Blood Pressure
- Mitral Valve Prolapse
- Past Surgeries
- Rheumatic Fever
- Other _____

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 reflux
- Heart Burn
- Hepatitis
- Past Surgeries
- Other _____

None for this system

REPRODUCTIVE

- STD'S
- 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: _____

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