



Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Sex [] M [] F [] Married [] Widowed [] Single [] Minor
[] Separated [] Divorced [] Partnered for ____ years
E-mail _____ Alt. Phone #1 (____) _____ Alt. Phone #2 (____) _____
Employer/School _____ Employer/School Phone (____) _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent'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 _____ Relation to Patient _____
Address _____ Home Phone (____) _____
Driver's License # _____ Birthdate _____ Bank _____
Employer _____ Work Phone (____) _____
Currently a patient in our office? [] Yes [] No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

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

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

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

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------------------|--|--|--|---------------------------------|--|--|--|---------------------------------|--|---------------------------------------|---|---|---|--|---|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|------------------------------------|---------------------------------------|---|-------------------------------------|------------------------------------|--|--|-----------------------------------|-----------------------------------|---|--|--|------------------------------------|--|--|--|--|--|------------------------------------|---------------------------------|---|---|--|--------------------------------------|---------------------------------------|--------------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Feet or Ankles | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Venereal Disease |

List medications you are currently taking and the correlating diagnosis:

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

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 the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment here at Division Smiles is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire lab analysis
- For payment purposes, we may use the services of a billing service
- During dental care operations, we may need a second opinion
- Referral to specialist may require a sharing of information
- Release of information at your request

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

If you have any questions or comments regarding your Protected Health Information, please contact our office at (503) 760-1341.

I have read and understand the above Notice of Privacy Practices.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Printed Name: _____