



## PATIENT INFORMATION

Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ SS # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status (please circle)    S    M    D    W  
How did you hear about our office? \_\_\_\_\_  
How may we contact you for appointment reminders? (please circle all that apply)  
email    work phone    home phone    cell phone    cell phone text message

## INSURANCE INFORMATION

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ SS # \_\_\_\_\_  
Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

## DENTAL HISTORY

### Are you have any of the following problems?

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, jaw joint, neck pain
- ☐ Dry mouth, difficulty swallowing
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Sleep apnea, snoring

### Do you have or have you had any of the following?

- ☐ Dentures/Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

### Do you smoke or chew tobacco? How much?

Why did you leave your previous dentist?

### If you could change your smile, you would:

- ☐ Make them whiter and brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings w/tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

### Please rate on a scale of 1-10 (10 is highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where is your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

## MEDICAL HISTORY

**Please circle "Yes" or "No" to all questions below.**

Yes No Are you in good health?

Yes No Have you been told to take premedication/antibiotics before a dental treatment?

If yes, for what reason? \_\_\_\_\_

Yes No Any change in your health within the last year? \_\_\_\_\_

Yes No Hospitalized or a serious illness within the last 5 years? \_\_\_\_\_

Yes No Being treated by a physician now? For what? \_\_\_\_\_

Yes No Do you have any allergies? \_\_\_\_\_

### Do you have or have you ever had?

Yes No Shortness of breath

Yes No Sinus Problems

Yes No Asthma

Yes No Emphysema

Yes No Tuberculosis

Yes No Sleep apnea/snoring

Yes No High Blood Pressure

Yes No Heart Disease

Yes No Heart Murmur

Yes No Mitral Valve Prolapse

Yes No Stroke

Yes No Heart Attack

Yes No Heart Defect

Yes No Pacemaker

Yes No Prosthetic Heart Valve

Yes No Chest Pain

Yes No Anemia

Yes No Bleeding problem

Yes No HIV positive/AIDS/ARC

Yes No Hepatitis A B or C

Yes No Stomach problem/ulcer

Yes No Diabetes

Yes No Kidney/bladder-disease

Yes No Thyroid/adrenal disease

Yes No Liver Disease

Yes No Herpes/Cold sore/ fever blister

Yes No Human papillomavirus

Yes No Seizures

Yes No Dizziness, fainting

Yes No Depression

Yes No Anxiety

Yes No Surgeries

Yes No Artificial Joint

Yes No Cancer

Yes No Radiation

Yes No Chemotherapy

### Do you take or have you ever taken:

Yes No Recreational drugs

Yes No Alcohol

Yes No Tobacco in any form

Yes No Fosomax/ Osteoporosis meds

Yes No Contraception/birth control

Yes No Vitamins

Yes No Medications - list below

\_\_\_\_\_ to treat \_\_\_\_\_

\_\_\_\_\_ to treat \_\_\_\_\_

\_\_\_\_\_ to treat \_\_\_\_\_

\_\_\_\_\_ to treat \_\_\_\_\_

\_\_\_\_\_ to treat \_\_\_\_\_

\_\_\_\_\_ to treat \_\_\_\_\_

Do you have or have you had any other medical problems not listed above? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (guardian if a minor)

\_\_\_\_\_  
Date

## PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing California Law requires (in addition to our attempt to obtain your written acknowledgement discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to our consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with

### PATIENT ACKNOWLEDGEMENT

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our Notice of Privacy Practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Patient Name (please print)*

\_\_\_\_\_  
*Date*

#### **FOR OFFICE USE ONLY:**

*Patient Refused to Sign*

The following circumstances prohibited the patient from signing acknowledgement:

An emergency situation prevented the patient from signing the acknowledgement:

\_\_\_\_\_  
*Office Personnel (Signature)*

\_\_\_\_\_  
*Office Personnel Name (print)*

\_\_\_\_\_  
*Date*

### PATIENT CONSENT

*Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above. I consent to the use of a testimonial I write and/or before and after photos for education and marketing purposes.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Patient Name (please print)*

\_\_\_\_\_  
*Date*