



THE DENTAL SPECIALTY CENTER

ORTHODONTICS • ENDODONTICS • PERIODONTICS • ORAL SURGERY

Welcome to Our Practice

Please complete the following:

Patient Information • Insurance Information & Financial Consent
HIPPA Compliance • Health and Medical History • Advanced Diagnostics
and Informed Consent

Patient Information

Name _____ Today's Date _____
E-mail _____ Date of Birth _____ Age _____ Sex _____
Address _____ Phone (h) _____ SS# _____
City _____ State _____ Zip _____ Phone (c) _____ Employer _____
Emergency Contact _____ Relationship _____ Phone _____
Pharmacy Name _____ Pharmacy Phone # _____

Referring General Dentist Information

Office Name _____ Date of Last Visit _____
Dentist Name _____ Date of Last Dental X-Ray _____
City _____ State _____ Zip _____ Office Phone Number _____

Insurance Information & Financial Consent

Dental Insurance

Primary Company _____ Policy Holder _____
Member ID # _____ Relationship _____ Employer _____
Group # _____ Date of Birth _____ SS# _____
Secondary Company _____ Policy Holder _____
Member ID # _____ Relationship _____ Employer _____
Group # _____ Date of Birth _____ SS# _____

Financial Consent

An approximated fee is required at the time of service. Verification of insurance benefits is always an estimate and never a guaranteed amount, as remaining dental maximums can be affected daily by multiple claims and providers. After treatment is complete, we will file an insurance claim as a courtesy for you. If for any reason your insurance does not pay what is expected, you will be financially responsible.

Signature

Date

HIPPA Consent

By signing below you are giving us consent to confirm appointments, disclose dental information requested by other treating dentists, leave messages/discuss medical or dental history with your pharmacist, request dental information from your insurance company, and/or request dental records when necessary and leave messages regarding your dental insurance. We are required by law to maintain the privacy of protected health information and provide individuals with a copy of our HIPPA compliance notice at the patient's request.

Signature

Date



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Medical Health History

Please answer ALL questions honestly and completely. All YES/NO questions must be answered.

HEIGHT _____ WEIGHT _____

LIST ALL SURGERIES AND DATES

DO YOU SMOKE? Yes No

How many cigarettes a day? _____

How many years? _____

Any problems with anesthesia in the past? Yes No

Have you ever had a serious illness or hospitalization? Yes No

When was your last medical check-up and for what purpose?

Primary Physician's Name _____ Phone # _____

Address _____

Drug Allergies Yes No Pls list _____ Latex Allergy Yes No

PLEASE LIST ALL OF YOUR MEDICATIONS (INCLUDE CHRONIC PAIN MEDICATION, INSULIN, ASPIRIN, BIRTH CONTROL, BLOOD THINNERS, ETC.)

Check YES or NO on ALL of the following conditions which you have had in the past or you have right now.

	Yes	No		Yes	No		Yes	No
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	CPAP At Home	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery? When? _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints When/Which joint? _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis What type? _____ Treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest pain When/How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type/Location _____	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath When? _____	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Recreation/Drug Abuse Drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke? When _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 1 Type 2 Insulin <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Asthma How often do you need to use your inhaler _____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/ Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Home Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Seizures Type _____ Last seizure _____	<input type="checkbox"/>	<input type="checkbox"/>
Chronis Steroid Meds	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat What type _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Low Bone Density/Osteoporosis Medication? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant or Trying	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Pain	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Mental Illness Type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Gagging w/ Dental Work	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy Why/When? _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism/ Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines How Often? _____	<input type="checkbox"/>	<input type="checkbox"/>

Please list ALL medical problems not mentioned above _____

By signing below, I (patient or guardian) attest that I have given a complete and truthful medical history.

Signature

Date