

1. Patient Information

Patient's Name _____
Last First MI
Nickname _____ Male Female
Birthdate ____/____/____ Age _____
Home # (____) _____ Cell# (____) _____
Home Address: _____

City State Zip
SS#: _____ DL# _____
Marital Status: Child Single Married Widowed Divorced
Spouses Name: _____
Referred by: _____

2. Mother's Information (if minor)

Mother Step-mother Guardian
Name _____ Birthdate ____/____/____
Work # (____) _____ Ext. _____
Home # (____) _____ Cell# (____) _____
Employer _____
SS# _____ DL# _____

3. Father's Information (if minor)

Father Step-father Guardian
Name _____ Birthdate ____/____/____
Work # (____) _____ Ext. _____
Home # (____) _____
Employer _____
SS# _____ DL# _____

4. Employment Information

Name: _____
Phone #: _____ Ext. _____

5. Emergency Contact (someone who does not live with you)

Name _____ Relation _____
Address: _____

City State Zip
Home # _____ Work # _____
Cell # _____

6. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Phone # (____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____ SS# _____
Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Phone # (____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____ SS# _____
Policy Owner's Employer _____

8. I Understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services needed.

Signature of Patient or Guardian (if minor) Date

Acknowledgement of receipt of notice of privacy practices

HIPPA

I, _____ have read a copy of this office's notice of Privacy Practices, located in the reception area of Hanosh Family Dentistry.

Health History Information

1. Are you having pain or discomfort at this time? **Yes No** Where: _____
2. Have you been under the care of a medical doctor during the past two years? **Yes No**
 Physician's Name _____ Phone # _____
 Address _____
3. 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**

4. Do you have or have you ever had? **(Please circle individually yes or no)**

Arthritis	Yes	No	Arteriosclerosis	Yes	No
Asthma	Yes	No	Artificial Joint (hip, knee, etc)	Yes	No
Allergies or Hives	Yes	No	A.I.D.S./HIV/STD	Yes	No
Anemia	Yes	No	Blood Thinners/Coumadin/Plavix	Yes	No
Blood Transfusion	Yes	No	Cancer	Yes	No
Chemotherapy	Yes	No	Cortisone Medicine	Yes	No
Cosmetic Surgery	Yes	No	Cold sores / Fever Blisters	Yes	No
Diabetes	Yes	No	Drug Addiction	Yes	No
Developmentally Disabled	Yes	No	Emphysema	Yes	No
Epilepsy or Seizures	Yes	No	Fainting or Dizzy Spells	Yes	No
Glaucoma	Yes	No	Heart Murmur	Yes	No
Heart Pacemaker	Yes	No	Hemophilia	Yes	No
Hepatitis A (infectious)	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Jaundice	Yes	No
Kidney Problems	Yes	No	Liver Disease	Yes	No
Low Blood Pressure	Yes	No	Mitral Valve Prolapse	Yes	No
Nervousness	Yes	No	Psychiatric Treatment	Yes	No
Radiation Therapy	Yes	No	Rheumatic Fever	Yes	No
Sinus Trouble	Yes	No	Stroke	Yes	No
Tuberculosis	Yes	No	Thyroid Problems	Yes	No
TMJ Problems	Yes	No	Ulcers	Yes	No

5. **Are you allergic to?**

Aspirin	Yes	No	Barbiturate	Yes	No
Codeine	Yes	No	Penicillin	Yes	No
Sulfa	Yes	No	Latex	Yes	No
Other	_____				

6. **Medications:**

List any medications you are currently taking:

7. Do your ankles swell during the day? **Yes No**
8. Have you lost or gained more the 10 pounds in the past year? **Yes No**
9. Do you ever wake up from sleep and feel short of breath? **Yes No**
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? **Yes No**
11. Female patients: Are you pregnant? **Yes No** If yes, when is your due date? _____
 Are you nursing? **Yes No** Are you taking birth control pills? **Yes No**

Consent:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable; including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

Lastly, I understand that all responsibility for payment of dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1.5% monthly finance charge (18% APR) may be added to my account, and where appropriate, credit bureau reports may be obtained. Should accounting or legal services be necessary to collect overdue payments, I agree to pay all costs associated with these proceedings.

X

Patient Signature_____
Date:_____
Parent/Guardian Signature (If patient is a child or requires a guardian)_____
Date