

\_\_\_\_\_  
*[Insert Name of Practice]*

**SECTION A: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE.**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

*Include this acknowledgement of receipt in the individual's records.*

**ACKNOWLEDGEMENT OF RECEIPT OF  
PRIVACY PRACTICES NOTICE**

welcome

PATIENT NUMBER

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(800) 243-4675

Age \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ ☐ Male ☐ Female  
Last First Initial

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you \_\_\_\_\_

**DENTAL INSURANCE  
1ST COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**DENTAL INSURANCE  
2ND COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_





|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|

PATIENT NUMBER

Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE  
WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

## COMMENTS

1. Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Tel: (\_\_\_\_) \_\_\_\_\_
2. Are you under a physician's care? .....YES NO  
Since when \_\_\_\_\_ Why \_\_\_\_\_
3. When was your last complete physical exam? \_\_\_\_\_
4. Are you taking any medication or substances? .....YES NO  
(If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ..YES NO
6. Are you allergic to any medications or substances? (please list) .....YES NO
7. Do you have any other allergies or hives? .....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics  
or other medications? .....YES NO
9. Are you sensitive to any metals or latex? .....YES NO
10. Are you pregnant or suspect you may be? .....YES NO
11. Do you use any birth control medications? .....YES NO
12. Have you ever been treated for or been told you might have heart disease? .....YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or  
been diagnosed with mitral valve prolapse? .....YES NO
14. Have you ever had rheumatic fever? .....YES NO
15. Are you aware of any heart murmurs? .....YES NO
16. Do you have high or low blood pressure? (please circle) .....YES NO
17. Have you ever had a serious illness or major surgery? .....YES NO  
If so, explain \_\_\_\_\_
18. Have you ever had radiation treatment, chemo treatment for tumor,  
growth or other condition? .....YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment  
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ..YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? .....YES NO
21. Do you have any artificial joints/prosthesis? .....YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .....YES NO
23. Have you ever bled excessively after being cut or injured? .....YES NO
24. Do you have any stomach problems? .....YES NO
25. Do you have any kidney problems? .....YES NO
26. Do you have any liver problems? .....YES NO
27. Are you diabetic? .....YES NO
28. Do you have fainting or dizzy spells? .....YES NO
29. Do you have asthma? .....YES NO
30. Do you have epilepsy or seizure disorders? .....YES NO
31. Do you or have you had venereal or any sexually transmitted disease? .....YES NO
32. Have you tested HIV positive? .....YES NO
33. Do you have AIDS? .....YES NO
34. Have you had or do you test positive for hepatitis? .....YES NO
35. Do you or have you had T.B.? .....YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? .....YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? .....YES NO
38. Do you habitually use controlled substances? .....YES NO
39. Have you had psychiatric treatment? .....YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with  
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? .....YES NO
41. Do you have any disease condition, or problem not listed? If so, explain \_\_\_\_\_
42. Is there anything else we should know about your health that we have not covered in this form? \_\_\_\_\_
43. Would you like to speak to the Doctor privately about any problem? .....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT