



Patient Information

Name: (Last) _____ (First) _____ (MI) _____
Preferred Name: _____ Gender (circle one): Male Female
Marital Status (circle one): Married Single Child Other: _____
Date of Birth: _____ Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Phone (Home): _____ (Work): _____
(Cell): _____ Does your cell phone allow text messages? ___yes ___no
(Text messages will only be used for appointment reminders)
Email address for appointment reminders: _____
Best form of contact: (circle one) Phone call Text message Email

Patient's Employment Information:

Employer Name: _____ Occupation: _____

Referral Information:

Whom may we thank for referring you to our office?

Circle one: Internet Yellow Pages Outside Sign Another Patient

If another patient referred you, name of patient: _____

Insurance Information

Do you have dental insurance? ___yes ___no Are you the primary policy holder? ___yes ___no
If No, name of policy holder: _____ Relationship to patient: _____
Policy holder's birth date: _____ Policy holder's social security #: _____
Policy holder's employer: _____ Dental Insurance Co. Name: _____
Group #: _____ Insurance Co. Phone #: _____

Patient's Dental Health History

Reason for today's visit: _____ Date of last dental cleaning: _____

Previous Dentist's Name: _____ Location of previous dentist (city, state): _____

Please check if you have any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Jaw locking when open/close | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Jaw pain/tiredness | <input type="checkbox"/> Sensitivity to bite |
| <input type="checkbox"/> Burning sensation in mouth | <input type="checkbox"/> Jaw clicking/popping | <input type="checkbox"/> Sensitivity to cold/brushing |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Swollen/tender gums |
| <input type="checkbox"/> Grinding/clenching teeth | <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Ulcers/sores in mouth |

Do you smoke? yes no If yes, amount: _____

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

Are you currently experiencing any dental discomfort? yes no

If yes, please explain: _____

Have you ever had altered taste perceptions? yes no

Have you ever noticed, or been told you grind your teeth? yes no

Do you ever wake up with a sore jaw, sore neck, or headache? yes no

Have you ever considered whitening your smile? yes no

Do you feel that you would like to improve your smile? yes no

If yes, please explain: _____

Medical Health History

Physician's name: _____ Phone Number: _____

Has there been any change in your general health within the past year? yes no

Have you had any serious illness or surgery? yes no

Have you been hospitalized in the past two years? yes no

If you answered yes to any of the above three questions, please explain: _____

Females: Are you pregnant? yes no Are you breast feeding? yes no

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Please check any of the following conditions that you currently or previously have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Neuralgia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis (type A, B, other) | <input type="checkbox"/> Previous tobacco user |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV, AIDS, ARC, ANTI-HIV | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Chronic cough/sore throat | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Current tobacco user | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Head or jaw injury | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Neck or back injury | |

Please check any of the following that you are ALLERGIC to or have ever had an unfavorable reaction to:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Codeine allergy | <input type="checkbox"/> Local anesthetic (novacaine, etc.) | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Penicillin allergy | <input type="checkbox"/> Barbiturates, sleeping pills | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Metals (rings, earrings, etc.) | <input type="checkbox"/> Iodine |

Do you have any other known allergies to medications? _____

Please check any medications that you are currently taking:

- | | | |
|---|--|---|
| <input type="checkbox"/> Antibiotics or sulfa drugs | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Insulin or similar drug |
| <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Cortisone (steroids) | <input type="checkbox"/> Medicine for high blood pressure |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Digitalis or other heart drug | <input type="checkbox"/> Multivitamins |
| <input type="checkbox"/> Aspirin (regular, ongoing basis) | <input type="checkbox"/> Herbal supplements | |

Please list the names of all medications that you are currently taking on a regular basis, including any supplements: _____

Have you ever been instructed by your physician to pre-medicate before your dental appointment? yes no

If yes, are you still currently taking your pre-medication? yes no

If yes, what is the type and dosage of your pre-medication? _____

Consent for Services

Since Dr. Burgess is not participating as a preferred provider with any insurance companies, you are responsible for your services in full at the time they are rendered. All insurance payments will be made to the primary policy holder.

If you have dental insurance, we will only file your insurance for you, if we may keep your signature on file. This will only authorize the release of your information to insurance companies. This signature on file form and authorization to release information will allow us to file your insurance claims for you electronically. This authorizes any provider, insurer, or other organization to release any information regarding your dental history, treatment, or benefits payable for the claim to the plan administrator or its authorized agents to determine benefits payable. Do we have your permission to keep a signature on file form? **If you choose no, we WILL NOT be able to file your insurance for you.** ___ yes ___ no

We take photographs of patients before and after extensive cosmetic treatment. These pictures allow others to visualize the dramatic effects of dentistry. We will place these photos in our reception area for other patients to view. We will not show any photos to other patients without your consent. Do we have your permission, if you undergo extensive cosmetic treatment, to place your photos in our reception area? ___ yes ___ no

Every appointment is reserved **exclusively** for each patient. We reserve the right to charge a minimum of \$35.00 for any appointments cancelled or broken without 24 hours advance notice. Please acknowledge that you understand our cancellation policy by initialing here: _____

To the best of my knowledge, all of the information provided is true and accurate. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail. I have read the above conditions of treatment and payment and I agree to their content.

Signature of patient, parent or guardian: _____ Date: _____

Relationship to patient: _____

HIPAA Consent Form

Effective April 14, 2003, the new 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. From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. We may need to consult with another dentist or healthcare professional in order for us to provide your treatment.

Patient Acknowledgment

Please sign below to acknowledge you have received a copy of our notice of privacy practices.

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

Patient Signature: _____ **Date:** _____

Patient Name (please print): _____