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 #: _____

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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:

___Bad breath	___Jaw locking when open/close	___Periodontal treatment
___Bleeding gums	___Jaw pain/tiredness	___Sensitivity to bite
___Burning sensation in mouth	___Jaw clicking/popping	___Sensitivity to cold/brushing
___Chew on one side of mouth	___Loose teeth or broken fillings	___Sensitivity to heat
___Dry mouth	___Lip or cheek biting	___Sensitivity to sweets
___Food collection between teeth	___Mouth breathing	___Swollen/tender gums
___Grinding/clenching teeth	___Pain around ear	___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:

___ Anemia
___ Arthritis
___ Asthma
___ Bruise easily
___Cancer
___Chronic cough/sore throat
___ Current tobacco user
___ Diabetes
___Epilepsy
___Frequent Headaches
___Head or jaw injury
___Heart disease/attack
___ Heart murmur
___ Heart surgery
___ Hepatitis (type A, B, other)
___ High blood pressure
___ HIV, AIDS, ARC, ANTI-HIV
___ Jaundice
___ Joint Replacement
___Kidney disease
___Liver disease
___Migraine headaches
___Mitral valve prolapse
___Neck or back injury
___ Neuralgia
___Pacemaker
___ Previous tobacco user
___ Radiation treatment
___ Respiratory problems
___ Rheumatic fever
___ Sinus problems
___ Stroke
___Tuberculosis
___Tumors
___Ulcers

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

___Codeine allergy
___Penicillin allergy
___ Latex allergy
___Local anesthetic (novacaine, etc.)
___Barbiturates, sleeping pills
___Metals (rings, earrings, etc.)
___Sulfa drugs
___Aspirin
___Iodine

Do you have any other known allergies to medications? _____

Please check any medications that you are currently taking:

___Antibiotics or sulfa drugs
___Anticoagulants (blood thinners)
___Antihistamines
___Aspirin (regular, ongoing basis)
___Chemotherapy
___Cortisone (steroids)
___Digitalis or other heart drug
___Herbal supplements
___Insulin or similar drug
___Medicine for high blood pressure
___Multivitamins

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): _____