THE DENTAL SPACE

Today's Date:_____/_____/_____

Patient Information

Patient's Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Male☐ Female☐

Address _____ City _____ State _____ Zip _____

Telephone (*Mobile*) _____ (*Home*) _____ (*Work*) _____

How did you hear about our office?_____

Parent/Guardian Information (If Patient is a minor)

Last Name _____ First Name _____ Middle Initial _____

Relationship to Patient _____ Date of Birth _____

Address (*if different*) _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (*Home*) _____ (*Work*) _____

Email Address _____

Insurance Information

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Date of Birth _____	Date of Birth _____
Relationship to Patient Self☐ Spouse☐ Child☐ Other_____	Relationship to Patient Self☐ Spouse☐ Child☐ Other_____
Insurance Company _____	Insurance Company _____
Member ID _____	Member ID _____
Group Number _____	Group Number _____
Employer _____	Employer _____
Insurance Phone Number _____	Insurance Phone Number _____

Emergency Contact Name _____ Relationship _____ Phone _____

Consent for Initial Exam

I consent to the diagnostic procedures necessary to perform an Initial Exam, which may include any necessary radiographs, intra-oral/extra-oral exam.

Signature (*responsible party if patient is a minor*) _____ Date _____

Dental History

Reason for Today's Visit _____

Are you currently experiencing dental pain or discomfort? Yes☐ No☐ (*If yes, Where*)_____

Are there any other concerns we should be aware of?_____

When did you last visit a Dentist? _____

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?.....	☐	☐	☐
Is your Mouth Dry?.....	☐	☐	☐
Do you grind your teeth?.....	☐	☐	☐
Do you wear Dentures or Partials?.....	☐	☐	☐

How do you feel about your smile? _____

Patient's Last Name _____ **First Name** _____ **DOB** ____/____/____ **Today's Date** ____/____/____

Patient Medical History

Are you under the care of a Physician now? Yes☐ No☐ Physician's name _____

Have you every been hospitalized or had a major operation/surgery? Yes☐ No☐

If yes, Please Explain _____

Have you every had a serious head or neck injury? Yes☐ No☐ *If yes, Please Explain* _____

Please list any medications that you are currently taking

Medication	Dosage	How Often	Route (Oral / Injection etc)

Do you use tobacco? (smoking, snuff, chew, bidis) Yes☐ No☐

Do you drink Alcoholic beverages? Yes☐ No☐ If yes, about how many drinks per week? _____

Do you use controlled substances? Yes☐ No☐

Are you Allergic to any of the following? Latex☐ Local Anesthetic☐ Penicillin☐ Aspirin☐ Codeine☐ Metal☐

Sulfa Drugs☐ Acrylic☐ Other_____

Women Only- Are you Pregnant? Yes☐ No☐ Number of weeks_____ Nursing? Yes☐ No☐

Taking birth control pills? Yes☐ No☐

Medical History - *Do you have or have you had any of the following?*

Artificial Heart Valve	Yes☐	No☐	Dizzy / Fainting Spells	Yes☐	No☐	Psychiatric Care	Yes☐	No☐
Artificial Joints	Yes☐	No☐	Down Syndrome	Yes☐	No☐	Rheumatic Fever	Yes☐	No☐
AIDS / HIV	Yes☐	No☐	Emphysema	Yes☐	No☐	Scarlet Fever	Yes☐	No☐
Anemia	Yes☐	No☐	Epilepsy / Seizures	Yes☐	No☐	Shortness of Breath	Yes☐	No☐
Angina / Chest Pains	Yes☐	No☐	Frequent Cough	Yes☐	No☐	Sickle Cell Anemia	Yes☐	No☐
Arthritis, Rheumatism	Yes☐	No☐	Glaucoma	Yes☐	No☐	Sinus Trouble	Yes☐	No☐
Asthma	Yes☐	No☐	Heart Attack / Failure	Yes☐	No☐	Skin Rash	Yes☐	No☐
- (required hospitalization)	Yes☐	No☐	Heart Disease	Yes☐	No☐	Stroke	Yes☐	No☐
Autism	Yes☐	No☐	Heart Murmur	Yes☐	No☐	Swelling of feet or ankles	Yes☐	No☐
Bleeding / Clotting Problems	Yes☐	No☐	Heart Valve Prolapse	Yes☐	No☐	Thyroid Problems	Yes☐	No☐
Blood Disorder	Yes☐	No☐	Heart Pacemaker	Yes☐	No☐	Tonsillitis	Yes☐	No☐
Birth Defect	Yes☐	No☐	Hepatitis (type _____)	Yes☐	No☐	Tuberculosis	Yes☐	No☐
Bronchitis	Yes☐	No☐	Herpes	Yes☐	No☐	Tumor/ growth (head/neck)	Yes☐	No☐
Cancer	Yes☐	No☐	High Blood Pressure	Yes☐	No☐	Ulcers	Yes☐	No☐
Cerebral Palsy	Yes☐	No☐	High Cholesterol	Yes☐	No☐	Unexplained weight loss	Yes☐	No☐
Chemo / Radiation Therapy	Yes☐	No☐	Immune Deficiency	Yes☐	No☐	Any other serious illness not listed above?		
Cold Sores / Fever Blisters	Yes☐	No☐	Jaundice	Yes☐	No☐	_____		
Congenital Heart Disorder	Yes☐	No☐	Kidney Disease	Yes☐	No☐			
Convulsions	Yes☐	No☐	Low Blood Pressure	Yes☐	No☐	_____		
Diabetes	Yes☐	No☐	Osteoporosis / Osteopenia	Yes☐	No☐			

The Information I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my/my child's health and/or medications. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me/my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Patient's Signature _____ Date _____/_____/_____

(Parent / Legal Guardian if Patient is a minor)

THE DENTAL SPACE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT AND REVIEW IT CAREFULLY.

Summary:

By law we are required to provide you with our Notice of Privacy Practices (NNP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As apatient you have the following rights:

1. The right to inspect a copy of your information;
2. The right to request corrections on your information;
3. The right to request your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical protected health information is secure with us. This Notice of Privacy Practices contains information how we ensure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this Notice of Privacy Practices. I further understand that the practice will offer me updates to this notice. Should it be modified or changed in any way I will receive a copy.

_____
Printed Name of Patient

_____
Signature of Patient/Parent/Legal Guardian