CLINTON|FAMILY|DENTAL

PATIENT INFORMATION:

Patient Legal Name:____Preferred Name:________________________

Birth Date:_______________ Male:___ Female___ Married___ Single___

SS#__________________________ Driver's License#____
_
Address:____City:__________________State:_____Zip:_______________

Home Phone#:_____________________ Work#:__________________________ Cell#:____________________________

Employer:____

Emergency Contact:____ Phone#:________________________________

How Did You Hear Of Us?____

PARENT/GUARDIAN INFORMATION (if patient is a minor):

Name:____Relationship to patient:_______________________

Birth Date:___________________ SS#________________________ Drivers License#:______________________________

Address:___________________________________City:____________________State:_________Zip_______________

Home Phone#:______________________ Work#:__________________________ Cell#___________________________

DENTAL INSURANCE INFORMATION (Primary):

Policyholder's Name:_______________________________DOB:________________SS#__________________________

Policyholder's Home Address:____

Insurance Company:____Group#________________________

Policy Holder's ID#:_____________________________ Employer:____

Patient Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_________________________________

I authorize payment by my insurance company directly to the dentist or Clinton Family Dental. I authorize the use of this signature on all insurance submissions. I authorize Clinton Family Dental to release all information necessary to secure the payment of benefits.

Signature____Date ____________________________

I understand that I am financially responsible for all charges whether or not paid by insurance. If my account must be turned over to a collection agency, a collection fee of 30% of the outstanding balance will be added to my account. In addition, I will be responsible for any legal fees, court cost, and attorney fees.

Signature____Date____________________________

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PATIENT NAME: ____

Physician's Name, Phone Number and Address ____

____

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height: ☐
Weight: ☐

For Office Use Only
BP: ☐ Heart Rate: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	Bisphosphonate Therapy
☐	☐	Bone Condition
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Drug Allergy - Other
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	High Blood Pressure
☐	☐	Latex Allergy
☐	☐	Multiple Myeloma
☐	☐	Osteoporosis
☐	☐	Penicillin Allergy
☐	☐	Radiation Therapy
☐	☐	Stroke
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis

Y	N	Conditions
☐	☐	Blood Transfusion
☐	☐	Bruise Easily
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hepatitis
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Substance Abuse
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Pain In Jaw Joints
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Fever Blisters

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

____

____

____

Please list all prescription and over-the-counter medications you are currently taking, as well as the condition for which the medication is being taken (Please attach separate medication list if necessary).

Have you ever been told by a doctor that you need to take antibiotics prior to dental appointments? ____________________________

If there are any other diseases, conditions or problems that you think we should be aware of that is not covered above, please describe here: ____

____

By signing below, I attest that I have completed the above information to the best of my knowledge.

Signature______________________________Date______________________

CLINTON|FAMILY|DENTAL

Acknowledgement of Receipt of

Notice of privacy Practices

Clinton Family Dental

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Signature: ____

Date: ____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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