PATIENT INFORMATION

(PLEASE PRINT)

S.S.# _____ DATE _____

NAME _____ BIRTHDATE _____ PREFERRED PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ OTHER ADDITIONAL PHONE _____

PATIENT'S EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

PHYSICIAN'S NAME AND PHONE NUMBER _____

RESPONSIBLE PARTY (IF MINOR OR DEPENDENT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO BIRTHDATE _____

DENTAL INSURANCE INFORMATION - PRIMARY

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SSN OR ID# _____

NAME OF EMPLOYER _____

INSURANCE COMPANY _____ GROUP #_____ PPO _____ YES OR NO

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INS. CO. PHONE NUMBER _____

NOTICE OF PRIVACY PRACTICES

BY SIGNING THIS FORM, I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE DENTAL OFFICE'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT MY DENTIST FOR MORE INFORMATION.

PLEASE COMPLETE
MEDICAL HISTORY ON BACK

Medical History

Has there been any change in your general health within the past year? If yes, Explain _____

My last physical examination was on _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, what was the illness or problem?_____

Are you taking any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? _____

_____

Have you ever taken medication for osteoporosis? Medication name: _____

(CIRCLE ANY THAT APPLY, & EXPLAIN) Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, heart defects)
c. Do you have a cardiac pacemaker or implanted defibrillator?
d. Asthma, hay fever or allergies
e. Diabetes
f. Hepatitis, jaundice or liver disease
g. AIDS or HIV infection or STI
h. Arthritis or painful swollen joints
i. Tuberculosis/Persistent cough
j. Low blood pressure - High blood pressure
k. Epilepsy or other neurological disease
l. Problems with mental health
m. Cancer
n. Problems of the immune system
o. Seasonal allergies

Have you had abnormal bleeding?

a. Have you ever required a blood transfusion?

Do you have any blood disorder such as anemia?

Have you ever had any treatment for a tumor or growth?

Allergies:

a. Local anesthetics
b. Penicillin
c. Other Medications _____
d. Latex

Have you had any serious trouble associated with any previous dental treatment?

If so, explain _____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about?

If so, explain _____

_____

Has your physician instructed you to premedicate when visiting the dentist? If yes, please list the medication you take _____

_____

Women

Yes No Are you pregnant?
Yes No Are you nursing?
Yes No Are you using oral contraceptives?

By way of my signature, I provide the office of Abt Dental Associates with my authorization and consent to use and disclose my protected dental care information for the purpose of treatment, payment and dental care operations.

By way of my signature, I agree to be responsible for all charges for dental services.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

SIGNATURE OF PATIENT (OR GUARDIAN) RELATIONSHIP TO PATIENT