MIDTOWN FAMILY DENTISTRY

PATIENT INFORMATION

Last Name: _____

Preferred Name: _____

Birth Date: _____ Social Security: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Responsible Party (if someone other than patient)

Last Name: _____ First: _____

Birth Date: _____ Social Security: _____-_____-_____

Drivers License: _____

Address, City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Spouse, Parent, Guardian: _____

Relationship to Patient: _____

Primary Insurance Info:

Name of Policy Holder: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder ID or SS: _____ Employer: _____

Policy Holder Date of Birth: _____ Group # _____

Insurance Company: _____ Address: _____

Telephone Number: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Phone: _____

Pharmacy: _____ Phone: _____

MIDTOWN FAMILY DENTISTRY

DENTAL HISTORY

Name of Patient: _____

Patient Account No _____

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. All information is confidential.

What is the reason for your visit today? _____

Date of last dental visit? _____ Last dental cleaning _____ Last full mouth x-rays _____

What was done at your last dental visit? _____

Previous Dentist's name _____ Phone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (interplak, toothpick, etc.)? _____

Do you have dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in between your teeth? ☐ Yes ☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Bite your lips or cheek regularly? ☐ Yes ☐ No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No

Mouth breath while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning ☐ Yes ☐ No

Snore of have any other sleep disorders? ☐ Yes ☐ No

Smoke/chew tobacco or use other tobacco products ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral Surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Your teeth ground or the bite adjusted? ☐ Yes ☐ No

A bite plate or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth or head? ☐ Yes ☐ No

If yes, please describe including cause: _____

_____

Have you experienced:

Clicking or Popping of the jaw? ☐ Yes ☐ No

Pain (joint, ear, side of face)? ☐ Yes ☐ No

Difficulty in opening or closing the mouth? ☐ Yes ☐ No

Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No

Headaches, neck aches or shoulder aches? ☐ Yes ☐ No

Sore muscles (neck, shoulder)? ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? _____

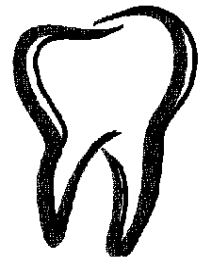
Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____



Name of Patient: _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care?	☐ Yes	☐ No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medication, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-fen or Redux?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

Women: Are you: Pregnant / Trying to get pregnant?	Yes	No	Taking Oral contraceptives?	Yes	No	Nursing?	Yes	No

Are you allergic to any of the following:	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal	☐ Latex	☐ Local Anesthetics
☐ Other: If yes, please explain:						

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Renal Dialysis	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Scarlet Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Arthritis / Gout	☐	☐	Epilepsy or Seizures	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Asthma	☐	☐	Fainting Spells/ Dizzy	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal Disease	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐			
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsilitis	☐	☐
Chest Pains	☐	☐	Hay Fever	☐	☐	Pain in Jaw Joints	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Attack/Failure	☐	☐	Parathyroid Disease	☐	☐	Tumors or Growth	☐	☐
			Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Ulcers	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pace Maker	☐	☐	Radiation Treatments	☐	☐	Venereal Disease	☐	☐
Convulsions	☐	☐	Heart Trouble/ Disease	☐	☐	Recent Weight Loss	☐	☐	Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed above? ☐ Yes ☐ No	Other: If yes, please explain:
Medications / Vitamins / Supplements:	
Comments:	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any charges in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

MIDTOWN FAMILY DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____ understand that Midtown Family Dentistry is required to request this signature by federal law and acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Full Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

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

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other: (Please specify)

Authorization to Release Information Purpose:

This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, _____ authorized the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Print Name / Relationship: _____

Print Name / Relationship: _____

Print Name / Relationship: _____

MIDTOWN FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION - COMPOUND RELEASE

Name of Patient: _____ Date of Birth: _____

is authorized to released protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information.
Check each person/entity that you approve to receive information.

Description of Information to be released. Check each that can be given to person/entity on the left in the same direction.

☐ Voice Mail

☐ Results of lab tests/x-rays
Other _____

☐ **Spouse (provide name and phone number)**
Name: _____
Phone: _____

☐ **Financial**
☐ **Medical**

☐ **Parent (provide name and phone number)**
Name: _____
Phone: _____

☐ **Financial**
☐ **Medical**

☐ **Email Communication - provide email address***
Name: _____
*In order for email communication to occur, please accept the disclosure below:

☐ **Financial**
☐ **Medical**
☐ **Breach Notification**

☐ For email communication, I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communications.

☐ Communication about treatment alternatives if this office is being compensated for making the communication.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by patient.

_____ _____

Signature of Patient or Personal Representative Date

*Description of personal Representative's Authority (attach necessary documentation)