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Roswell Dental Care Patient Information

Patient's Name________________________________ Today's date____________

Birthdate __________ Age _____ Gender ___________ SSN________________

Address ____________________________________

____________________________________ Marital Status ___________

Referred by____

Contact Information: Please provide at least 2 ways to be contacted.

Home ________________Cell________________Work_______________

Email ____

Employer ____

Employer's Address ______________________________________

Occupation ________________________________ Length of employment _______

Spouse Information

Name________________________________ Date of Birth ____________

Employer ______________________________ Occupation ____________

Cell Phone ____________________ Work Phone _________________________

Person Responsible for Account ____________________ Date of Birth ____________

Employer ______________________________ Occupation ____________

Cell Phone ____________________ Work Phone _________________________

Emergency Contact ___________________________ Relationship___________

Cell Phone ____________________ Work Phone _________________________

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name ____

Insurance Company Address __________________________ Phone ______________

Insured's Name_____________ **Date of Birth** _________ **SSN** ______________

Insured's Employer_________________ Address ___________________________

Group Number__________________ ID Number ___________________________

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name ____

Insurance Company Address __________________________ Phone ______________

Insured's Name_____________ **Date of Birth** _________ **SSN** ______________

Insured's Employer_________________ Address ___________________________

Group Number__________________ ID Number ___________________________

Patient Health History

Today's Date: / /

NAME: ____DATE OF BIRTH: ____

Please check any of the following conditions that apply to your health history:

___Anemia
___Arthritis
___Asthma
___Cancer
___Chest Pain with Exertion
___Diabetes Type I; Type II
___Emphysema
___Epilepsy
___Fainting Spells
___Fatigue Easily
___Glaucoma
___Heart Disease
___Heart Murmur
___Heart Valve Replacement
___Hepatitis or Jaundice
___High Blood Pressure
___History of Alcoholism
___HIV Positive
___Intestinal Problems
___Joint Replacement_______________________________________
___Kidney or Bladder Disease
___Low Blood Pressure
___Nervous Disorder
___Osteoporosis
___Pacemaker
___Pregnant
___Prolonged Bleeding
___Rheumatic Fever
___Shortness of Breath
___Sleep Apnea
___Swollen Ankles
___Thyroid Disease
___Tobacco Use
___Tuberculosis
___Venereal Disease
___X-ray Therapy to Head or Neck

Have you been treated for any other condition in the past year? ____
Have you been hospitalized in the past 5 years? If so, why? ____
Are you taking any medications to treat bone loss? ____
Have you ever been diagnosed with a sleep disorder? ____
Do you have a history of snoring? ____
Do you have trouble sleeping? ____

Do we have permission to use Nitrous Oxide (laughing gas)?	YES	NO
Do you feel self-conscious about your breath?	YES	NO
Do you ever feel a coating on your tongue?	YES	NO
Do you brush or scrape your tongue?	YES	NO
Are you interested in whiter teeth?	YES	NO
Do you wear contacts?	YES	NO

Previous Dentist_____________________________________ Primary Care Doctor____
When was your last dental exam? ______________________ cleaning? _______________________ x-rays? ____________________

Please list current medications, prescription and over-the-counter:

PLEASE LIST **DRUG ALLERGIES** INCLUDING, BUT NOT LIMITED TO:

PENICILLIN	YES	NO	NOT SURE
ASPIRIN	YES	NO	NOT SURE
CODEINE	YES	NO	NOT SURE
LOCAL ANESTHETIC	YES	NO	NOT SURE
OTHER__________________			

Notice of Privacy Practice Acknowledgement

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my health information. I understand these rights and understand that the Notice of Privacy Practices containing a description of the uses and disclosures of my health information is available for my review.

PATIENT NAME (PLEASE PRINT):____

RELATIONSHIP TO PATIENT:____

SIGNATURE:____DATE:_____________________

I have attempted to obtain the patient's signature in acknowledgement of this notice, but was unable to do so as documented below:

NAME:____DATE:_____________________

REASON:____

Insurance Policy and Financial Agreement Today's Date: / /

PATIENT NAME____

DATE OF BIRTH__________________________

Payment for services is expected at the time of service unless other arrangements have been made with our office.

As a courtesy, we will submit your insurance on your behalf. You will be responsible for any co-payments at the time of service.

We request that you pay your pre-determined patient portion at the time of service. When your insurance company pays us, any remaining balance will be your responsibility.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I understand I am responsible for any financial obligation for treatment on myself or aforementioned patient.

I understand a credit verification can be requested if treatment is financed.

I understand a fee will be assessed for recovery if I fail to meet my financial obligation.

I affirm that the information I have given today is correct to the best of my knowledge and I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

PRINT NAME:____

SIGNATURE:___________________________________ Date:____________________________________