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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:_____