New Patient Forms

Date _____/______/______

Last Name ___________________________ First Name ____________________________ MI ___________
Sex: M F Date of Birth: ____/____/____ Age ___ Single/Married/Widowed SSN ____-____-______
Mailing Address ____ City______________________
State ________________, Zip Code ______________Cell Phone__________________________________
Home Phone ______________________________ Email ____
Occupation ______________________________Employer _______________________________________
Best Contact: cell phone/home phone/ email. Name of Emergency Contact_______________________
Relationship________________________Phone ___________________________

Parent/Guardian/Legal Representative

Last Name _____________________________ First Name ____________________________ MI ___________
Sex: M F Date of Birth: ____/____/_____. SSN ____-____-__________
Mailing Address ____, City____________________ State ______
Cell Phone ___________________ Home Phone ___________________ Email: _______________________
Employer _____________________________

Insurance Information (Please bring a copy of your insurance card(s) for us to copy)

Employee (Policy Holder) Name _________________________ Birthdate _____/_____/_______
Relationship to patient ______________ SSN ____-___-_______ Employer _________________________
Ins. Company _________________________________ Ins. Phone _________________________________
Ins. Address _____________________________________City______________State________________
Policy # (ID) _____________________ Group # _____________________
Secondary Insurance: Yes No (If yes, list same information on back of form and bring your card)

Responsibility Statement

Payment is expected when services are rendered. We accept cash, personal checks, VISA, MasterCard, American Express and Discover. We also offer options for financing. We will file insurance claims on your behalf. Your insurance is a method for you to receive reimbursement for fees you have paid to or incurred with the doctor for services rendered. I agree to be financially responsible for all charges.

I, the undersigned patient/guardian, hereby authorize the release of my information for treatment, payment and other health care operations. I have read the above information and understand it.

After being entered in our secure electronic database, this form will be shredded and destroyed.

____ ____________________________________

Signature: Patient, Parent, Guardian Date Witness Date

Dental History

	Yes	No
Are you experiencing pain in your mouth or jaw at this time? • If yes, where and for how long?		
Have you had any serious trouble in the past associated with dental treatment?		
Have you ever had orthodontic treatment (braces)?		
Do your teeth have sensitivity to hot, cold, sweets?		
Are you aware of having periodontal disease?		
Do you clench or grind your teeth during the day or while sleeping?		
Does your jaw click or pop or cause pain when you open or close your mouth?		
Do your gums bleed when brushing or flossing?		
Do you notice any loose teeth?		
How often do you brush your teeth?		
Have you ever had a history of or suspected oral cancer?		
Are you physically unable to care for yourself or need a caregiver to help clean your mouth?		
On a scale of 1-5 (5 being worst), how fearful of the dentist are you?		
How often do you get your teeth cleaned?		
What type of toothbrush do you use? (Manual/Normal) (Mechanical/Electric)		
What other oral hygiene aids do you use? (Floss, waterpik, etc.)		
At this time, what is your biggest dental concern?		
Referred or seen by (general dentist or practice)		
Last dental visit (month/year)		

Medical History:

Are you currently under the care of a physician? Yes. No. Name(s): ______________________________

Have you been hospitalized in the last 5 years? If so, why? _____________________________________

Do you have a history of medications for osteoporosis, or bisphosphonates for cancer? Yes. No

Known Allergies: Latex/ Penicillin/ Amoxicillin/Sulfa Drugs/ Other Drug Allergies:

____

Other Allergies (food, seasonal) ____

Medications

Medicine	Dosage (mg)	Frequency (times per day)

Medicine	Dosage (mg)	Frequency (times per day)

Do you require antibiotic premedication prior to dental work: Yes. No. Reason? ___________________

Please check if you currently have, or have a history of the following:

Heart Disease		Gastrointestinal Disease		Bleeding disorder/problem	
High Blood Pressure		Weight Loss		Hemophilia	
Low Blood Pressure		Hepatitis		Anemia	
Angina		Immunosuppressive Disease		Leukemia	
Rheumatic Fever		HIV/AIDS		Lung Disease	
Kidney Disease or Dialysis		Osteoporosis		COPD/Emphysema	
Fainting/Dizziness		Cancer/Chemotherapy		Shortness of Breath	
Eating Disorder		Alcohol/Drug Dependency		Asthma	
Stomach Reflux		Thyroid Disease		Sleep Apnea	
Stomach Ulcer		Blood Transfusion		Tuberculosis	
Sjogren's Disease		Glaucoma		Sinus infection or disease	
Immunological Disease		Heart Murmur		Radiation treatment	
Fibromyalgia		Mitral Valve Prolapse		Adverse reaction- Anesthesia	
Autoimmune Disease		Heart Surgery		Trauma to Head/Neck	
Arthritis (Osteo, Rheumatoid)		Artificial Heart Valve		Syndrome affecting teeth	
Diabetes, Type ___. HbA1c _____		Pacemaker		Heart arrythmia	
Depression		Defibrillator		Perceived poor health	
Psychiatric Disorders		Artificial Joints		Osteoporosis	
Neurological Disease		Organ Transplant		Epilepsy	
Tobacco Use		Stroke		Other:	

Do you have any medical conditions, diseases, or problems not listed in the chart above? Please explain.

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Women only:

Are you pregnant? Yes. No.

Are you nursing? Yes. No.

Are you using oral contraceptives? Yes. No.

Are you undergoing fertility treatment or taking fertility medications? Yes. No.

The following information is for our records and will be entered into our secure electronic database. This form will be scanned and destroyed for your protection.

I certify that I have read and understand the above. I understand that every effort will be made to protect my personal and medical information. 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 the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ Patient, Parent, or Guardian
Date:

Acknowledgement of Receipt of HIPAA Policies and Procedures

I have received and reviewed a copy of our dental practice privacy, security, and breach notification policies and procedures. I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Signature: ____

Agreement to Receive Electronic Communication

I agree that the dental practice may communicate with me electronically at the email address below and by sending text messages to the cell phone number below. I am aware that there is some level of risk that third parties may be able to read unencrypted emails. I am responsible for providing the dental practice with any updates to my email address/cell phone number. I can withdraw my consent to electronic communications by calling (704) 484-0148 or emailing info@foothillsperio.com.

Email: Yes No

Cell Phone Number: Yes No

I do not wish to have electronic communication.

Signature: ____

______________________ **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 the obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other:** ____________________________________