Thank you for choosing us! We want your visit to be pleasant and comfortable. Please help us by completing this form.

Personal Information

Name of Patient: ______________________________ DOB: ____________ Age: ______________

Address: ______________________________ City: ______________ State: _____ Zip: ____________

Home Phone: ________________ Cell Phone: __________________ Work Phone:_________________

Marital Status: Single/Married Gender: Male/Female

Employer: ______________________________ Occupation: ________________________________

In case of Emergency, who should be notified? __________________________ Phone: _______________

Whom may we thank for referring you? ____

If patient is a minor:

Name of Patient's Authorized Representative: ____

Address: ______________________________ City: ______________ State: _____ Zip: ____________

Home Phone: ________________ Cell Phone: __________________ Work Phone:_________________

Relationship to Patient: ______________________________

Insurance Information

Primary Dental Insurance

Insurance Company:________________ Insurance ID Number: ____________ Group Number: ___________

Subscriber Name: _____________________________ Relationship to Patient: _________________

Employer: _______________________ Subscriber DOB: _______________________________

Secondary Dental Insurance

Insurance Company:________________ Insurance ID Number: ____________ Group Number: ___________

Subscriber Name: _____________________________ Relationship to Patient: _________________

Employer: _______________________ Subscriber DOB: _______________________________

Continued on the next page…

Dental History

Reason for today's visit:____

Last Dental Exam: _______________ Last Dental X-rays: _______________ Previous Dentist: _______________

Do you have or have you ever had?

Anxiety about dental treatment	Y	N	Jaw "popping" or "clicking"	Y	N
History of smoking/chewing tobacco	Y	N	Orthodontic treatment	Y	N
Bleeding gums when brushing/flossing	Y	N	Dry mouth	Y	N
Periodontal disease	Y	N	Reaction to dental anesthetic	Y	N
Cavities or fillings	Y	N	Problems with dental treatment	Y	N
Do you brush daily?	Y	N	Do you floss daily?	Y	N

Medical History

Do you have or have you ever had?

1. Hospitalization for illness or injury Y N
2. An allergic reaction to:
   - ❏ Aspirin, ibuprofen, tylenol
   - ❏ Penicillin
   - ❏ Erythromycin
   - ❏ Local Anesthetic
   - ❏ Codeine
   - ❏ Fluoride
   - ❏ Metals
   - ❏ Acrylic
   - ❏ Latex
   - ❏ Sulfa
   - ❏ Other _____________
3. Heart problems Y N
4. Heart attack Y N
5. Heart valve replacement Y N
6. Pacemaker Y N
7. Congenital heart defect Y N
8. Rheumatic fever Y N
9. Scarlet fever Y N
10. High blood pressure Y N
11. Low blood pressure Y N
12. A stroke Y N
13. Artificial heart valve Y N
14. Artificial joint Y N
15. Anemia or other blood disorder Y N
16. Prolonged bleeding Y N
17. Emphysema Y N
18. Tuberculosis Y N
19. Asthma Y N
20. Kidney Disease Y N
21. Liver Disease Y N
22. Jaundice Y N
23. Thyroid or Parathyroid Disease Y N
24. High Cholesterol Y N
25. Diabetes Y N
26. Stomach or duodenal Ulcer Y N
27. Digestive disorder Y N
28. Osteoporosis/osteopenia Y N
29. History of bisphosphonate use Y N
30. Arthritis Y N
31. Glaucoma Y N
32. Head or neck injuries Y N
33. Epilepsy or seizures Y N
34. Neurological problems Y N
35. Viral infections or cold sores Y N
36. Lumps or swellings in the mouth Y N
37. Hepatitis (Type ______) Y N
38. HIV/AIDS Y N
39. STDs Y N
40. Cancer Y N
41. Radiation therapy Y N
42. Chemotherapy Y N
43. Antidepressant medication Y N
44. Alcohol Dependency Y N
45. Drug dependency Y N
46. FEMALE - currently pregnant Y N
47. FEMALE - currently on birth control Y N
48. MALE - prostate disorders Y N

Please list any other conditions/diseases not listed above. _______________________________________

____

Please list all medications, supplements and vitamins taken in the last 3 years.

____

____

_______________________________ _______________________________

Patient signature *Date* *Doctor signature* *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____ have received a copy of this office's Notice of Privacy Practices.

____

Signature of Patient or Patient's Authorized Representative *Date*

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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please specify) _______________________________________

Insurance Authorization

I understand that dental insurance policies are an arrangement between an insurance carrier and me. I authorize the assignment of my insurance benefits (if applicable) and the use of electronic signature on all insurance submissions. I authorize Chappell Family Dentistry to release and/or request records to or from other providers as necessary.

____
Initial

Treatment Authorization

I authorize the dentist and the staff of the dental office to perform necessary dental services, including but not limited to x-rays and the administration of local anesthesia. In addition, the above authorization applies to my child whether or not I am present when treatment is rendered.

____
Initial

Financial Policy

I agree to pay for dental services in full at the time of treatment, or to pay the estimated portion and/or copays associated with my dental insurance unless mutually agreed to by Chappell Family Dentistry and myself. I understand that any remaining balance after insurance payments will be billed to me. **I agree that I am responsible for all bills incurred by me at this office whether or not they are paid by insurance.**

____
Initial

____

Signature of Patient or Patient's Authorized Representative *Date*

____

Name of Patient's Authorized Representative (Please print)

____

Description of Legal Authority to Act on Behalf of Patient

____