

## Patient Information

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Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Referring Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## Dental Insurance (if you have your cards don't fill this out)

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Primary Ins. Co. \_\_\_\_\_ Employer \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Birthdate \_\_\_\_\_ ID or SSN \_\_\_\_\_

Secondary Ins. Co. \_\_\_\_\_ Employer \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Birthdate \_\_\_\_\_ ID or SSN \_\_\_\_\_

## Statement of Privacy Practices

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I have read the attached *Statement of Privacy Practices*. I understand it describes my rights and the responsibilities and duties of this office with respect to my protected health information. In addition to the allowable disclosures described, I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

Any member of my immediate family Yes  No

Spouse only Yes  No

Other (specify) \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had any of the following (please circle):

AIDS-HIV

Alcohol addiction

Anemia

Asthma

Cancer

Congenital heart lesions

Diabetes

Drug addiction

Epilepsy

Frequent headaches

Glaucoma

Heart murmur

Heart valves

Hepatitis

High blood pressure

Jaundice

Low blood pressure

Prosthetic joints

Psychiatric treatment

Rheumatic fever

Sinus trouble

Stroke

Ulcers

- 1 Has there been any change in your general health during the past year? \_\_\_\_\_ Yes  No
- 2 Have you been a patient in a hospital in the past two years? \_\_\_\_\_ Yes  No
- 3 Do you require antibiotics prior to any dental treatment? Yes  No
- 4 Are you allergic to any medicines? \_\_\_\_\_ Yes  No
- 5 Any excessive bleeding from a cut or tooth extraction? \_\_\_\_\_ Yes  No
- 6 Do you think your teeth are shifting or moving? \_\_\_\_\_ Yes  No
- 7 Do you grind or clench your teeth? \_\_\_\_\_ Yes  No
- 8 Do you smoke cigars or cigarettes? How much per day? \_\_\_\_\_ Yes  No
- 9 Do you take any medication for Osteoperosis? \_\_\_\_\_ Yes  No

FEMALES ONLY:

- 1 Are you pregnant? \_\_\_\_\_ Yes  No

Please list all your daily medications – be sure to include blood thinners (Plavix, Coumadin, etc).

I give my consent for evaluation only, and no invasive treatment will be performed prior to discussion of the proposed treatment with Dr. Rogers or his staff. I understand that in some instances a local anesthetic may be needed for diagnostic purposes. If this is needed, it will not be performed without my permission. If I have any questions about my recommended treatment, I can ask for an explanation at any time.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_