Patient Information

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)

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

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	Epilepsy	Low blood pressure
Alcohol addiction	Frequent headaches	Prosthetic joints
Anemia	Glaucoma	Psychiatric treatment
Asthma	Heart murmur	Rheumatic fever
Cancer	Heart valves	Sinus trouble
Congenial heart lesions	Hepatitis	Stroke
Diabetes	High blood pressure	Ulcers
Drug addiction	Jaundice	

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: _____