ABOUT YOU

Today's Date: _____

Name: _____ I prefer to be called: _____ ○Male ○Female
(Last) (First) (Middle)

Birth date: _____ Social Security #: _____

Marital Status: ○Single ○Married ○Divorced ○Widowed ○Separated

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____ Driver's License #: _____

Who may we thank for referring you? _____

Who is responsible for payment on this account? _____

Emergency Contact

Name: _____ Relation: _____ Home Phone: _____

Address: _____
Street City State Zip

Spouse Information

Name: _____ Birth date: _____ Social Security #: _____

Insurance Information

Primary Insurance Name: _____ Group # (Plan, Local or Policy #): _____

Dental Coverage? ○Yes ○No Orthodontic Coverage? ○Yes ○No

Phone #: _____

Ins. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birth date: _____ Insured's Employer: _____

Insured's ID #: _____ Relation: _____

Secondary Insurance Name: _____ Group # (Plan, Local or Policy #): _____

Dental Coverage? ○Yes ○No Orthodontic Coverage? ○Yes ○No

Phone #: _____

Ins. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birth date: _____ Insured's Employer: _____

Insured's ID #: _____ Relation: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME: _____ *Birth Date:* _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○Yes	○No	*If yes, please explain:* _____
Have you ever been hospitalized or had a major operation?	○Yes	○No	*If yes, please explain:* _____
Have you ever had a serious head or neck injury?	○Yes	○No	*If yes, please explain:* _____
Are you taking any medications, pills, or drugs?	○Yes	○No	*If yes, please explain:* _____
Do you take, or have you taken, Phen-Fen or Redux?	○Yes	○No	
Are you currently or have you taken bisphosphonates?	○Yes	○No	*If "yes" circle one: Actonel, Boniva, Didronel, Aredia, Zometa, other*
Are you on a special diet?	○Yes	○No	
Do you use tobacco?	○Yes	○No	
Do you use controlled substances?	○Yes	○No	

Women: Are you
Pregnant/Trying to get pregnant? ○Yes ○No *Taking Oral Contraceptives?* ○Yes ○No *Nursing?* ○Yes ○No

Are you allergic to any of the following?
Aspirin ☐ *Penicillin* ☐ *Codeine* ☐ *Acrylic* ☐ *Metal* ☐ *Latex* ☐ *Local Anesthetics* ☐ *Other* ☐

If Yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○Yes ○No	*Excessive Bleeding*	○Yes ○No	*Lung Disease*	○Yes ○No
Alzheimer's Disease	○Yes ○No	*Excessive Thirst*	○Yes ○No	*Mitral Valve Prolapse*	○Yes ○No
Anaphylaxis	○Yes ○No	*Fainting Spells/Dizziness*	○Yes ○No	*Pain in Jaw Joints*	○Yes ○No
Anemia	○Yes ○No	*Frequent Cough*	○Yes ○No	*Parathyroid Disease*	○Yes ○No
Angina	○Yes ○No	*Frequent Diarrhea*	○Yes ○No	*Psychiatric Care*	○Yes ○No
Arthritis/Gout	○Yes ○No	*Frequent Headaches*	○Yes ○No	*Radiation Treatments*	○Yes ○No
Artificial Heart Valve	○Yes ○No	*Genital Herpes*	○Yes ○No	*Recent Weight Loss*	○Yes ○No
Artificial Joint	○Yes ○No	*Glaucoma*	○Yes ○No	*Renal Dialysis*	○Yes ○No
Asthma	○Yes ○No	*Hay Fever*	○Yes ○No	*Rheumatic Fever*	○Yes ○No
Blood Disease	○Yes ○No	*Heart Attack/Failure*	○Yes ○No	*Rheumatism*	○Yes ○No
Blood Transfusion	○Yes ○No	*Heart Murmur*	○Yes ○No	*Scarlet Fever*	○Yes ○No
Breathing Problem	○Yes ○No	*Heart Pace Maker*	○Yes ○No	*Shingles*	○Yes ○No
Bruise Easily	○Yes ○No	*Heart Trouble/Disease*	○Yes ○No	*Sickle Cell Disease*	○Yes ○No
Cancer	○Yes ○No	*Hemophilia*	○Yes ○No	*Sinus Trouble*	○Yes ○No
Chemotherapy	○Yes ○No	*Hepatitis A*	○Yes ○No	*Spina Bifida*	○Yes ○No
Chest Pains	○Yes ○No	*Hepatitis B or C*	○Yes ○No	*Stomach/Intestinal Disease*	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	*Herpes*	○Yes ○No	*Stroke*	○Yes ○No
Congenital Heart Disorder	○Yes ○No	*High Blood Pressure*	○Yes ○No	*Swelling of Limbs*	○Yes ○No
Convulsions	○Yes ○No	*Hives or Rash*	○Yes ○No	*Thyroid Disease*	○Yes ○No
Cortisone Medicine	○Yes ○No	*Hypoglycemia*	○Yes ○No	*Tonsillitis*	○Yes ○No
Diabetes	○Yes ○No	*Irregular Heartbeat*	○Yes ○No	*Tuberculosis*	○Yes ○No
Drug Addiction	○Yes ○No	*Kidney Problems*	○Yes ○No	*Tumors or Growths*	○Yes ○No
Easily Winded	○Yes ○No	*Leukemia*	○Yes ○No	*Ulcers*	○Yes ○No
Emphysema	○Yes ○No	*Liver Disease*	○Yes ○No	*Venereal Disease*	○Yes ○No
Epilepsy or Seizures	○Yes ○No	*Low Blood Pressure*	○Yes ○No	*Yellow Jaundice*	○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No *If yes, please explain:* _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ *Date:* _____

Plum Grove Dental Associates
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____
Patient Name Date

_____
Signature (Guardian, if patient is under 18)

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

_____

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

COMMUNICATION INFORMATION

Communication is a very important part of providing quality health care. In an effort to provide you with information, we may contact you to provide appointment reminders, information about treatment or other health related services.

Patient Name: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email: _____

Which number do you prefer to be contacted at? *Home* *Work* *Cell* *Email* (please circle one)

Would you like to receive an appointment confirmation by Email? *Yes* *No* (please circle one)
(please remember to confirm the email)

Would you like to receive appointment reminders by Text Messaging? *Yes* *No* (please circle one)
(please remember to confirm the text message)

Name: _____
(please print)

Signature: _____ Date: _____

** This information will not be shared with any one**