

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Email Address: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment and the:  mother  father  
Name: \_\_\_\_\_  Married  Single  Child  Other \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
The following is for:  the patient's spouse  the person responsible for payment and the:  mother  father  
Name: \_\_\_\_\_  Married  Single  Child  Other \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

### Medical Information

Have you ever had any of the following? Please check those that apply:

- |  |   |  |   |                                       |
|--|---|--|---|---------------------------------------|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure   | Due date: _____                               | <input type="checkbox"/> Tumors       |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Ulcers       |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Respiratory Problems |                                       |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Hay Fever          | <input type="checkbox"/> Mental Disorder       | <input type="checkbox"/> Rheumatic Fever      |                                       |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Head Injuries      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatism           |                                       |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Sinus Problems       |                                       |

Have you ever had a reaction to any of the following? Please check those that apply:

Sulfa  Penicillin (Antibiotics)  Anesthetics like Novacaine  Aspirin  Codeine  Other: \_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you currently taking medicine regularly?  Yes  No  
If yes, what medicines? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment, Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code Phone

The following is for:  the patient's spouse  the person responsible for payment, Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code Phone

### Dental Insurance Information

Primary Insurance \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Name of Secondary Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_

### Dental History

Do you have any current dental problems?  Yes  No If yes, please explain: \_\_\_\_\_

Yes  No 1. Is this your first dental visit? If no, date of last complete dental examination. \_\_\_\_\_

Yes  No 2. Are your teeth sensitive?

Yes  No 3. Do your gums bleed or hurt?

Yes  No 4. Have you noticed any loose teeth or change in your bite?

Yes  No 5. Have you noticed any mouth odors or bad tastes?

Yes  No 6. Does food tend to become caught between your teeth?

Yes  No 7. Do you clench or grind your teeth?

Yes  No 8. Have you ever had Orthodontic treatment?

Yes  No 9. Have you ever seen a Periodontist?

Yes  No 10. Has your bite ever been adjusted?

Yes  No 11. Do you have clicking or popping in your jaw?

Yes  No 12. Do you have difficulty opening or closing your mouth?

Yes  No 13. Have you ever been told you have a TMJ problem?

Yes  No 14. Do you get frequent headaches?

Yes  No 15. Would you like to keep your teeth all your life?

Yes  No 16. Have you ever had any complications following dental treatment? If yes, please explain \_\_\_\_\_

Yes  No 17. Do you feel nervous about having dental treatment? If yes, what is your biggest concern? \_\_\_\_\_

Yes  No 18. Have you ever had an upsetting dental experience? If yes, please describe \_\_\_\_\_

Yes  No 19. Are you happy with the appearance of your teeth? If no, what would you like to change? \_\_\_\_\_

### Consent for Services

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.
5. I hereby give Dr. Pominville the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present future compensation in connection with the use of said photographs/slides.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**ADVANCED DENTAL CARE  
Anselum L. Pominville, DDS  
7626 North State Street  
Lowville, New York 13367  
315-376-3121**

**SECTION A: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:**

I attest that the above information is correct.

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

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGEMENT OF RECEIPT OF  
PRIVACY PRACTICES NOTICE**