

PATIENT INFORMATION

Name (First) _____ (Middle Initial) ____ (Last) _____ (Preferred/Nickname) _____
 Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ SS# _____ Sex M _____ F _____
 Married _____ Single _____ Child _____ E-mail address _____
 Phone Home (____) _____ Work (____) _____ x _____ Cell (____) _____
 Referred by _____ Employer/Occupation _____

SPOUSE INFORMATION

Name (First) _____ (Middle) _____ (Last) _____
 Date of Birth _____ SS# _____ Sex M _____ F _____ Employer _____
 Phone Home (____) _____ Work (____) _____ x _____ Cell (____) _____

PARENT INFORMATION (if patient is child)

Mother _____ Father _____ Step _____ Other _____
 Name (First) _____ (Middle) _____ (Last) _____
 Address _____
 City _____ State _____ Zip _____ Employer _____
 Date of Birth _____ SS# _____ Sex M _____ F _____
 Phone Home (____) _____ Work (____) _____ x _____ Cell (____) _____

Mother _____ Father _____ Step _____ Other _____
 Name (First) _____ (Middle) _____ (Last) _____
 Address _____
 City _____ State _____ Zip _____ Employer _____
 Date of Birth _____ SS# _____ Sex M _____ F _____
 Phone Home (____) _____ Work (____) _____ x _____ Cell (____) _____

PRIMARY DENTAL INSURANCE

Policy Holder _____ DOB _____
 Employer _____ Group # _____
 Insurance Company _____ ID# or SSN _____

SECONDARY DENTAL INSURANCE

Policy Holder _____ DOB _____
 Employer _____ Group # _____
 Insurance Company _____ ID# or SSN _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read a copy of Dr. Russell and Dr. Smith's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. A copy of the Notice is available upon my request. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice.

SIGNATURE: _____ DATE: _____

Print Name: _____

Relationship to Patient: Self Mother Father Other: _____

DENTAL HISTORY

Reason for today's visit? _____

Name of Last Dentist? _____

Last Cleaning? _____ Last X-rays? _____

WOMEN: (MEDICAL HISTORY)

Are you pregnant? Y N

Are you nursing? Y N

Due Date? _____

Taking Birth Control? Y N

Emergency Contact

Name _____

Phone Number _____

HEALTH HISTORY (please check all that apply)

- | | | |
|---|--|---|
| <p>Y N</p> <p><input type="radio"/> AIDS/HIV</p> <p><input type="radio"/> Anxiety/Nervous Problems</p> <p><input type="radio"/> Asthma</p> <p><input type="radio"/> Blood Disorder</p> <p><input type="radio"/> Anemia</p> <p><input type="radio"/> Other _____</p> <p><input type="radio"/> Blood Thinners (i.e.-Coumadin, Warfarin, Aspirin)</p> <p><input type="radio"/> Bones/Joints</p> <p><input type="radio"/> Arthritis/Rheumatism</p> <p><input type="radio"/> Artificial Joints</p> <p><input type="radio"/> Other _____</p> <p><input type="radio"/> Cancer (type) _____</p> <p><input type="radio"/> Chemotherapy</p> <p><input type="radio"/> Radiation Therapy</p> | <p>Y N</p> <p><input type="radio"/> Cold Sores/Fever Blisters/Herpes</p> <p><input type="radio"/> Cortisone/Steroid Treatment</p> <p><input type="radio"/> Diabetes (circle) type 1/type 2</p> <p><input type="radio"/> Drug/Alcohol Abuse</p> <p><input type="radio"/> Emphysema/Respiratory Disease</p> <p><input type="radio"/> Epilepsy</p> <p><input type="radio"/> Fainting/Dizziness</p> <p><input type="radio"/> Fen-Phen (Diet Pills)</p> <p><input type="radio"/> Heart Problems</p> <p><input type="radio"/> Artificial Heart Valves</p> <p><input type="radio"/> Congenital Heart Lesions</p> <p><input type="radio"/> Heart Disease</p> <p><input type="radio"/> Heart Murmur</p> <p><input type="radio"/> Mitral Valve Prolapse</p> <p><input type="radio"/> Pacemaker</p> <p><input type="radio"/> Other _____</p> | <p>Y N</p> <p><input type="radio"/> Hepatitis (type) _____</p> <p><input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> Kidney Disease</p> <p><input type="radio"/> Liver Disease</p> <p><input type="radio"/> Low Blood Pressure</p> <p><input type="radio"/> Migraines/Frequent Headaches</p> <p><input type="radio"/> Premedicate (prior dental procedure)</p> <p><input type="radio"/> Psychiatric Care</p> <p><input type="radio"/> Rheumatic Fever/Scarlet Fever</p> <p><input type="radio"/> Skin Rash</p> <p><input type="radio"/> Stroke</p> <p><input type="radio"/> Thyroid Problems</p> <p><input type="radio"/> Tuberculosis</p> <p><input type="radio"/> Tumor</p> <p><input type="radio"/> Weight Loss, unexplained</p> <p><input type="radio"/> Eating Disorder</p> |
|---|--|---|

Physician's Name _____ Phone (____) _____

Have you had any recent surgeries/hospitalizations? (past 5 years) _____

ALLERGIES

- Y N**
- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Flavoring Agents (i.e.-Mint/Cinnamon)
- Iodine
- Latex
- Local Anesthetics/Epinephrine
- Penicillin
- Sulfa
- Other _____
- _____
- _____

MEDICATIONS

Please list any medications you are currently taking and reason:

Have you ever been told you needed an antibiotic prior to dental treatment? (Circle one) YES NO

Pharmacy Name _____

Phone (____) _____

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for this activities and health care operations that are related to treatment.

Patient's / Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____