



PATIENT INFORMATION Today's Date : _____

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 _____

Doctor Preference Stephen Russell Grant Smith No preference

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 (____) _____

<p>PRIMARY DENTAL INSURANCE</p> <p>Policy Holder _____ DOB _____</p> <p>Employer _____ Group # _____</p> <p>Insurance Company _____</p> <p>ID# or SSN _____</p>	<p>SECONDARY DENTAL INSURANCE</p> <p>Policy Holder _____ DOB _____</p> <p>Employer _____ Group # _____</p> <p>Insurance Company _____</p> <p>ID# or SSN _____</p>
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DENTAL HISTORY

Reason for today's visit? _____ Name of Last Dentist? _____

Last Cleaning? _____ Last X-rays? _____

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: _____

HEALTH HISTORY (please indicate "yes" or "no")

- | | | |
|---|--|--|
| <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><input type="radio"/> Cold Sores/Fever Blisters/Herpes</p> | <p>Y N</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><input type="radio"/> Hepatitis (type) _____</p> | <p>Y N</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</p> <p><input type="radio"/> 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 (____) _____

WOMEN: Are you pregnant? Y N Due Date? _____
 Are you nursing? Y N Taking Birth Control? Y N

Emergency Contact _____
Phone # _____

You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lendor/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

I acknowledge that if I do not give 24 hours notice of cancellation (by phone call), I am responsible for a \$50 cancellation fee (subject to change).

I acknowledge that I (the patient), am responsible to know my insurance benefits, and benefits are not guaranteed until the insurance company has made payment.

I acknowledge that payment is due when services are rendered.

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** _____