WELCOME

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR DENTAL NEEDS. PLEASE COMPLETE THIS FORM IN INK.
IF YOU HAVE ANY QUESTIONS OR CONCERNS, DO NOT HESITATE TO ASK FOR ASSISTANCE.
WE WILL BE HAPPY TO HELP.

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____ DOB_____

SOCIAL SECURITY # _____ SEX MALE _____ FEMALE_____

ADDRESS _____CITY/ST/ZIP_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

E-MAIL ADDRESS_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

RESPONSIBLE PARTY INFORMATION

NAME_____ MARITAL STATUS_____

ADDRESS _____CITY/ST/ZIP_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

SOCIAL SECURITY # _____ DOB _____

EMPLOYER _____ OCCUPATION _____

DENTAL INSURANCE INFORMATION

POLICY OWNER'S NAME_____SS#_____ DOB_____

INSURANCE COMPANY _____ GROUP # _____ PHONE# _____

INSURED'S EMPLOYER_____

DO YOU HAVE A SECOND COVERAGE? YES _____ NO _____ IF YES:

POLICY OWNER'S NAME_____SS#_____ DOB_____

INSURANCE COMPANY _____GROUP#_____PHONE#_____

INSURED'S EMPLOYER_____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____

PHONE _____ RELATIONSHIP_____

DENTAL HISTORY

Name _____ **Age** _____
Former Dentist _____
Reason for today's visit _____
Date of last exam _____ **Date of last dental x-rays** _____
How often do you brush _____ **How often do you floss** _____
Please check any of the following conditions that apply to you:

___ bad breath	___ grinding teeth	___ sensitive to hot	___ clicking jaw
___ bleeding gums	___ broken teeth	___ unhappy with teeth	___ loose teeth
___ sensitive to cold	___ hurts to chew	___ sensitive to sweets	___ happy with teeth

If you checked "unhappy with teeth", what would you like to improve? (Circle all that apply)
COLOR SIZE SPACING ALIGNMENT SHAPE

MEDICAL HISTORY

Physician _____ **Date of last visit** _____
Have you ever taken bisphosphonates for osteoporosis (Zometa, Aredia, Boniva, Actonel, or Fosamax)?
_____
Have you ever had joint replacement surgery? _____
Please list all medications you are <u>currently</u> taking: _____
_____
Allergies: _____
(Women) Are you pregnant? _____ **Nursing?** _____

Do you have a history of the following? (Check the ones that apply)

___ Heart trouble	___ Rheumatic fever	___ Heart murmur
___ Tuberculosis	___ High blood pressure	___ Diabetes
___ Kidney disease	___ Liver disease	___ Epilepsy
___ Sickle cell	___ Prolonged bleeding	___ Smoking
___ Venereal disease	___ Ulcer	___ Thyroid problem
___ Stroke	___ Respiratory disease	___ Radiation treatment
___ Hepatitis	___ HIV	___ Mental problems
___ Blood disease	___ Shortness of breath	___ Smokeless tobacco

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

X_____
Signature of Patient (or Parent if a Minor) **Date**

1. Date: _____ Initials: _____ Comments: _____
_____
2. Date: _____ Initials: _____ Comments: _____
_____

LISA A. STRICKLAND, DMD, PC
ASHLEY G. BASSETT, DMD, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____