PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT) SOCIAL SECUIRTY #_____

NAME_____ BIRTHDATE _____ TODAY'S DATE _____

FIRST MI LAST

ADDRESS _____ CITY _____ STATE ____ ZIP _____

EMAIL _____ HOME PHONE _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE ____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

SOCIAL SECURITY # _____ BIRTHDATE _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE ____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE ____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____ **SIGNATURE**

SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT MEDICAL HISTORY

PATIENT NAME _____ TODAY'S DATE _____

PHYSICIAN _____ OFFICE PHONE_____ DATE OF LAST EXAM_____

ARE YOU UNDER MEDICAL TREATMENT NOW? Y N

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? Y N

DO YOU USE TOBACCO?_____ Y N

DO YOU, OR HAVE YOU USED CONTROLLED SUBSTANCES? Y N
IF YES, EXPLAIN_____

DO YOU, OR HAVE YOU TAKEN PHEN-FEN, REDUX, OR ORAL BISPHOSPHONATES? Y N

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS? _____ Y N

DO YOUR GUMS BLEED EASILY? Y N

DO YOU SUFFER FROM COLD SORES/CANKER SORES? Y N

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? _____ Y N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ PENICILLIN ☐ SULFA DRUGS ☐ BARBITUATES ☐ LOCAL ANESTHETICS ☐ NONE

☐ IODINE ☐ LATEX ☐ SEDATIVES ☐ ASPIRIN ☐ OTHER_____

WOMEN ONLY

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? Y N ARE YOU NURSING? Y N ARE YOU TAKING ORAL CONTRACEPTIVES? Y N

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

Y N HIGH BLOOD PRESSURE
Y N LOW BLOOD PRESSURE
Y N HEART ATTACK
Y N HEART MURMUR
Y N HEART DISEASE
Y N CARDIAC PACEMAKER
Y N ANGINA
Y N ARTIFICIAL HEART VALVE / STENT
Y N CONGESTIVE HEART FAILURE
Y N MITRAL VALVE PROLAPSE
Y N ARRHYTHMIA
Y N STROKE
Y N RHEUMATIC FEVER
Y N JOINT REPLACEMENT OR IMPLANT -TYPE_____

Y N DIABETES
Y N GLAUCOMA
Y N CANCER
Y N LEUKEMIA
Y N RADIATION THERAPY
Y N CHEMOTHERAPY (PORT Y/N)
Y N DIALYSIS (PORT Y/N)
Y N KIDNEY DISEASE
Y N ASTHMA
Y N EMPHYSEMA
Y N RESPIRATORY PROBLEMS
Y N EPILEPSY / CONVULSIONS
Y N THYROID PROBLEM

Y N ARTHRITIS
Y N HEPATITIS / JAUNDICE
Y N SEXUALLY TRANSMITTED DISEASE
Y N AIDS OR HIV INFECTION
Y N ANEMIA
Y N ALZHEIMER'S/ DEMENTIA
Y N LIVER DISEASE
Y N HAY FEVER / ALLERGIES
Y N TUBERCULOSIS
Y N RECENT WEIGHT LOSS
Y N PSYCHIATRIC CARE
Y N STOMACH TROUBLES / ULCERS
OTHER:_____

MEDICATIONS

_____

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SIGNATURE OF DENTIST: **DATE:**

SIGNATURE

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.

X _____ DATE
PATIENT, PARENT, OR GUARDIAN

X _____ DATE
PATIENT, PARENT, OR GUARDIAN

X _____ DATE
PATIENT, PARENT, OR GUARDIAN

X _____ DATE
PATIENT, PARENT, OR GUARDIAN

Kramer Family Dental Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

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

Print Name: _____

Signature: _____

Date: _____

For Office Only

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

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March 2016