Elite Family Dentistry

PATIENT INFORMATION Date___/___/_____

Name _____Cell Phone (___)_____Home Phone(____)_____
Address_____City_____ST____Zip_____
Driver's License #_____Birthdate___/___/___ Social Security #_____
Patient's or Parent's Employer_____Work Phone(____)_____
Employer's Address_____City_____ST____Zip_____
Spouse's Name_____Employer_____WorkPhone(____)_____
Emergency Contact Person_____Relation to patient_____Phone(____)_____

RESPONSIBLE PARTY

Name_____Relation to Patient_____
Address_____ Home Phone(____)_____
Driver's License #_____Birthdate___/___/___ Social Security #_____
Employer_____Work Phone(____)_____
Currently a Patient in our Office? Yes____ No____

INSURANCE INFORMATION

Name of Insured_____Relation to Patient_____
Birthdate___/___/_____ Social Security # _____ Date Employed___/___/_____
Employer_____ Work Phone(____)_____
Employer Address_____City_____ST___Zip_____
Insurance Company_____Group #_____Member ID#_____
Address_____City_____ST___Zip_____

SECONDARY INSURANCE INFORMATION

Name of Insured_____Relation to Patient_____
Birthdate___/___/_____Social Security #_____Date Employed___/___/_____
Employer_____Work Phone(____)_____
Insurance Company_____Group #_____Union or Local #_____
Address_____City_____ST___Zip_____

CONSENT FOR SERVICES

I have read and understand the above information and answered the questions to the best of my knowledge. I grant permission to be contacted by phone at home or at work regarding matters related to my treatment. I authorize the release of any information pertaining to my diagnosis or treatment to other health practitioners. I authorize insurance benefits to be paid directly to the dentist and authorize the release of all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. Please note--if you need to cancel an appointment for any reason we need at least 24 hours notice. Otherwise, a fee of $30 for the missed appointment may be assessed to your account.

Signature of Patient or Guardian_____ Date _____
Relationship to Patient _____

Patient Name: _____

DENTAL HISTORY

Reason for Today's Visit_____
Former Dentist_____ Phone(____)_____
Date of last dental visit_____Date of last X-rays_____

Check if you have any of the following:

__Bad Breath	__Grinding/clenching teeth	__Sensitivity to heat
__Bleeding gums	__Loose teeth or broken fillings	__Sensitivity to sweets
__Clicking or popping jaw	__Periodontal treatment	__Painful biting/chewing
__Food wedging between teeth	__ Sensitivity to cold	__Sores or growths in mouth

How often do you brush?_____ How often do you floss?_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____
Have you ever taken any of the group of drugs referred to as "fen-phen?" ___yes ___no
[These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluamine) and Redux (dexfenfluramine).]
Have you had any serious illnesses or operations? _____yes _____no
If yes, please describe_____
Have you ever had a blood transfusion? __ yes __no If yes, please give dates_____

WOMEN: Are you pregnant? __yes __no Nursing? __yes __no Taking birth control pills? __yes __no

Check if you have/ have had any of the following:

__Anemia	__Cortisone Treatments	__Hepatitis	__Scarlet Fever
__Arthritis, Rheumatism	__Cough, Persistent	__High Blood Pressure	__Shortness of Breath
__Artificial Heart Valves	__Cough up Blood	__HIV/AIDS	__Skin Rash
__Artificial Joints	__Diabetes	__Jaw Pain	__Stroke
__Asthma	__Epilepsy	__Kidney Disease	__Swelling of feet/ankles
__Back Problems	__Fainting	__Liver Disease	__Thyroid problems
__Blood Disease	__Glaucoma	__Mitral Valve Prolapse	__Tobacco Habit
__Cancer	__Headaches	__Pacemaker	__Tonsillitis
__Chemical Dependency	__Heart Murmur	__Radiation Treatment	__Tuberculosis
__Chemotherapy	__Heart Problems	__Respiratory Disease	__Ulcer
__Circulatory Problems	__Hemophilia	__Rheumatic Fever	__Venereal Disease

Current Medications and Dosages:

_____
_____
_____
_____
_____

Known Drug Allergies:

_____
_____
_____
_____
_____

Have you ever been told you need to take an antibiotic prior to dental care? _____ Yes _____ No

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THIS PRACTICE.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 30, 2006 and will remain in effect until we replace it.

We may use or disclose your health information to a physician or other health/dental care provider in order for them to provide continuity of care to you.

We may use and disclose your health/dental information to obtain payment for services we provide to you.

In addition to our use of your health/dental information for treatment or payment, you may give us written authorization to disclose your health/dental information to a family member, friend or other person to the extent necessary to help with your care or with payment arrangements. You may revoke this authorization in writing at any time.

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Please indicate any person/persons we are NOT to disclose information to on your behalf.

Name _____ Relationship _____

Name _____ Relationship _____

By signing below you indicate that you understand and agree with the above privacy policies. Please ask the OFFICE MANAGER any questions you may have or request further clarification if needed.

Patient Name _____

Patient/Parent /Guardian Signature _____

Date _____