

Patient Information:			
Last Name:	First Name:	MI:	
Name you Prefer:	Date of Birth:	Social Security #:	
Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	Work Phone:	Ext:
Email:			
Gender: M: [ ] F: [ ] O: [ ]		Married/Domestic Partner: Y:[ ] N:[ ]	
How did you hear about us? Drive by: [ ] Social Media/Website:[ ] Insurance:[ ] Family/Friend:[ ]			
Are any other members of your household a patient with us? Y:[ ] N:[ ] Name:			

*Primary Insurance:		
Insurance Company Name:		
Primary Subscribers Name(If different from the patient):		Date of Birth:
Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ]		Subscribers Social Security:
ID Number:	Group Number:	Effective Date:
Claims Address:		
Claims Phone Number:		

*Secondary Insurance:		
Insurance Company Name:		
Primary Subscribers Name(If different from the patient):		Date of Birth:
Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ]		Subscribers Social Security:
ID Number:	Group Number:	Effective Date:
Claims Address:		
Claims Phone Number:		

\*Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility, however, to pay your portion at time of service. If the necessary, please discuss other financial arrangements with our billing office.

Emergency Contact:		
Last Name:	First Name:	Spouse/Partner: Y:[ ] N:[ ]
Primary Phone:	Secondary Phone:	Patient Here: Y:[ ] N:[ ]

I acknowledged that I am financially responsible for all charges whether or not paid by insurance. The undersigned agrees to pay for all cost and expenses. I hereby authorize the office to release information necessary to secure the payment of benefits.

Signature:	
Patient Signature (or Guardian):	Date:

Name \_\_\_\_\_ DOB \_\_\_\_\_

**PRIMARY PHYSICIAN INFORMATION**

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Clinic/Facility: \_\_\_\_\_

**MEDICAL HISTORY**

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

Y  N Under a physician's care now?  
 Y  N Any hospitalization in the past 5 years? \_\_\_\_\_  
 Y  N Any serious illnesses/surgeries? \_\_\_\_\_  
 Y  N Use tobacco in any form? If Yes, Type: \_\_\_\_\_  
 Y  N Is pre-medication required before dental visits due to heart condition or artificial joint?  
 Y  N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS:  Y  N Currently nursing?  Y  N Currently pregnant? Due Date: \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
 If yes, please describe:  
 \_\_\_\_\_  
 Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe:  
 \_\_\_\_\_

**ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):**  NONE

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> BULIMIA	<input type="checkbox"/> HEAD INJURIES	<input type="checkbox"/> PREGNANCY
<input type="checkbox"/> ADHD	<input type="checkbox"/> CANCER/MALIGNANCY	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> PSYCHIATRIC TREATMENT
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> RADIATION
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> COUGH, PERSISTENT	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> ARTIFICIAL HEART VALVE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> STROKE
<input type="checkbox"/> ARTIFICIAL JOINTS	<input type="checkbox"/> DIZZINESS/FAINTING	<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> THYROID CONDITION
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EXCESSIVE BLEEDING	<input type="checkbox"/> MENTAL DISORDER	<input type="checkbox"/> ULCERS
<input type="checkbox"/> BACK PROBLEMS	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> OTHER - PLEASE LIST: _____	

**ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):**  NONE

<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> CODEINE	<input type="checkbox"/> LACTOSE INTOLERANCE	<input type="checkbox"/> Seasonal	<input type="checkbox"/> NONE
<input type="checkbox"/> ANESTHETIC - LOCAL	<input type="checkbox"/> DAIRY	<input type="checkbox"/> METAL SENSITIVITY	<input type="checkbox"/> SULFA DRUGS	
<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> LATEX	<input type="checkbox"/> NITROUS OXIDE SEDATION	<input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS	
<input type="checkbox"/> OTHER - PLEASE LIST: _____				

**MEDICATION INFORMATION**

**ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):**  NONE

<input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS	<input type="checkbox"/> ANTIHISTAMINES/ALLERGY	<input type="checkbox"/> DAILY ASPIRIN	<input type="checkbox"/> BLOOD PRESSURE MEDICATIONS
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> CANCER/CHEMO MEDICATIONS	<input type="checkbox"/> CORTISONE/STEROIDS	<input type="checkbox"/> HEART MEDICATION/DIGITALIS
<input type="checkbox"/> INSULIN	<input type="checkbox"/> NITROGLYCERIN	<input type="checkbox"/> ORAL CONTRACEPTIVES	<input type="checkbox"/> OSTEOPOROSIS MEDICATIONS
<input type="checkbox"/> OTHER DIABETIC MEDICATIONS	<input type="checkbox"/> RECREATIONAL DRUGS	<input type="checkbox"/> THYROID MEDICATIONS	<input type="checkbox"/> TRANQUILIZERS
<input type="checkbox"/> OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

## PREVIOUS DENTIST INFORMATION

Dentist: ..... Telephone: .....

Clinic/Facility: .....

Address: .....

CITY

ST

ZIP CODE

## DENTAL HISTORY

ORAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

Date of Last Dental Visit: ..... Treatment Type: .....

Y  N Are you currently having dental discomfort? If yes, explain: .....

Y  N Any unhappy/unpleasant dental experiences? If yes, explain: .....

Y  N Any injuries to mouth/teeth/head? If yes, explain: .....

Y  N Any missing teeth other than wisdom teeth or orthodontic extractions?

Y  N Have missing teeth been replaced?

Y  N Orthodontic appliances now or in the past?

Y  N Gums bleed when brushing or flossing?

Y  N Concerned about gum disease? History of gum disease?  Y  N

Y  N Any concerns about the appearance of your teeth?

Y  N Does it hurt to bite or chew?

Y  N Do you clench or grind your teeth? If so, do you wear a night guard or splint?  Y  N

Y  N Do you want to become a regular continuing care patient in our practice?

Y  N Do you want your mouth properly restored and pain free?

Y  N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient name: \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Our commitment here at Bridge City Smiles is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire lab analysis
- For payment purposes, we may use the services of a billing service
- During dental care operations, we may need a second opinion
- Referral to specialist may require a sharing of information
- Release of information at your request

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

**May we phone, email, or send a text to you to confirm appointments? YES NO**

**May we leave a message on your answering machine at home or on your cell phone? YES NO**

**May we discuss your medical condition with any member of your family? YES NO**

**If YES, please name the members allowed:**

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If you have any questions or comments regarding your Protected Health Information, please contact our office at (503) 282-0926.

**I have read and understand the above Notice of Privacy Practices.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Legal Guardian)

Printed Name: \_\_\_\_\_