PATIENT INFORMATION AND HEALTH

Date:____________

Last Name	First Name	MI	Age	Sex	Date of Birth
Social Security Number	Driver License Number	Employer Name			
Home Address	City	State	Zip Code		
Home Number ( )	Work Number ( )	Cell Number ( ) Email:			

Would you like to sign up for email/text reminders of upcoming appointments, specials or promotions? Yes /No Text or Email

***DENTAL INSURANCE** is the responsible party the same as the patient information above? Yes/ No

If you answered no, please fill out the information below. **If you do not have dental insurance, please initial here __________*

Insured Last Name	Insured First Name	Insured Date of Birth	Insured Social Security Number
Home Address	City	State	Zip Code
Employer Name and Address:	Employer Phone Number ( )		
Insurance Company Name and Address:	Insurance Company Phone Number ( )		
Group Name	Group Number	Member/Provider ID	

*PATIENT HEALTH

	Yes	NO	If yes, explain:
Are you currently under physician's care?	___	___	________________________________
Have you ever been hospitalized or had a major operation?	___	___	________________________________
Have you ever had a serious head or neck injury?	___	___	________________________________
Are you taking any medications, pills, or drugs?	___	___	________________________________
Do you take or have you taken Phen-Fen or Redux?	___	___	________________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	___	___	________________________________
Are you on a special diet?	___	___	________________________________
Do you use tobacco/controlled substances?	___	___	________________________________
Do you have to premedicate for appointments?	___	___	________________________________

Do you have any allergies? Yes ____ No ____ If yes, please list all allergies below:

____

Women are you:

Pregnant/ Trying to get pregnant? Yes ___ No ___ Taking Oral Contraceptives? Yes ___ No ___ Nursing? Yes ___ No ___

***Please indicate by a check mark if you have, or have had, any of the following?**

				__ Shingles
__ AIDS/HIV Positive	__ Chemotherapy	__ Frequent Diarrhea	__ Hives or Rash	__ Sickle Cell Disease
__ Alzheimer's Disease	__ Chest Pain	__ Frequent Headache	__ Hypoglycemia	__ Sinus Trouble
__ Anaphylaxis	__ Cold Sores	__ Genital Herpes	__ Kidney Problems	__ Spina Bifida
__ Anemia	__ Convulsions	__ Glaucoma	__ Leukemia	__ Stomach/Intestinal Desease
__ Angina	__ Cortisone Med	__ Heart Attack/Failure	__ Liver Disease	__ Stroke
__ Arthritis/Gout	__ Diabetes	__ Heart Murmur	__ Low Blood Pressure	__ Swelling of Limbs
__ Artificial Heart Valve	__ Drug Addictions	__ Heart Pacemaker	__ Lung Disease	__ Thyroid Disease
__ Artificial Joint	__ Easily Winded	__ Heart Trouble/Disease	__ Mitral Valve Prolapse	__ Tonsillitis
__ Asthma	__ Emphysema	__ Hemophilia	__ Osteoporosis	__ Tuberculosis
__ Blood Disease	__ Epilepsy/Seizures	__ Hepatitis A	__ Pain in Jaw Points	__ Tumors or Growths
__ Blood Transfusion	__ Excessive Bleeding	__ Hepatitis B or C	__ Parathyroid Disease	__ Ulcers
__ Breathing Problems	__ Excessive Thirst	__ Herpes	__ Psychiatric Care	__ Venereal Disease
__ Bruise Easily	__ Fainting/Dizziness	__ High Blood Pressure	__ Recent Weight Loss	__ Yellow Jaundice
__ Cancer	__ Frequent Cough	__ High Cholesterol	__ Rheumatic Fever	__ Other:______________

Patient/Guardian Signature: ______________________ Date: ______________ Staff Initials: __________

FINANCIAL POLICY AND AGREEMENT

Thank you for your support by allowing us to provide your dental care.
By signing the following statement, you indicate you have read and understood our financial policy agreement. If you have any questions, please do not hesitate to contact our office.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY:

PRINT PATIENT/GUARDIAN NAME ___________________________________ **DATE:**_________________________________

SIGNATURE OF PATIENT/GUARDIAN ____

NOTICE OF PRIVACY PRACTICES (DENTAL) POLICY

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. By signing the following statement, you indicate you have read and understood our HIPPA privacy rules. If you have any questions, please do not hesitate to contact our office.

Please indicate the person/persons your treatment can be disclosed to:
Name:___________________________________ **Relation**________________
Name:___________________________________ **Relation**________________
Name:___________________________________ **Relation**________________

I HAVE READ, UNDERSTAND, AND AGREE TO THE NOTICE OF PRIVACY PRACTICES HIPPA POLICY:

PRINT PATIENT/GUARDIAN NAME ___________________________________ **DATE:**_________________________________

SIGNATURE OF PATIENT/GUARDIAN ____

NOTICE OF NONDISCRIMINATION POLICY

Thank you for allowing us to provide your dental care.
By signing the following statement, you indicate you have read and understood our nondiscrimination policy. If you have any questions, please do not hesitate to contact our office.

I HAVE READ, UNDERSTAND, AND AGREE TO THE NOTICE OF NONDISCRIMINATION POLICY:

PRINT PATIENT/GUARDIAN NAME ___________________________________ **DATE:**_________________________________

SIGNATURE OF PATIENT/GUARDIAN ____

Staff Initials and Date:______________________

Foreign Language Assistance

- **Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (205) 621.5304.
- **Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(205) 621.5304。
- **Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (205) 621.5304 번으로 전화해 주십시오.
- **Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (205) 621.5304.
- **Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (205) 621.5304
- **German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (205) 621.5304.
- **French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (205) 621.5304.
- **Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (205) 621.5304.
- **Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (205) 621.5304.
- **Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (205) 621.5304पर कॉल करें।
- **Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (205) 621.5304.
- **Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (205) 621.5304.
- **Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (205) 621.5304.
- **Turkish:** DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. (205) 621.5304 irtibat numaralarını arayın.
- **Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(205) 621.5304 まで、お電話にてご連絡ください。

Staff Initials and Date: ________________________