OBEIDDENTAL

Patient Information

Name (Last, First Middle): _____

Date of Birth: _____ Social Security #: _____ Gender: ___ Male ___ Female

Address: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ Drivers License Number: _____ Issuing State: _____

Employer & Address: _____

Emergency Contact: _____ Contact Phone: _____

Whom may we thank for referring you to our office? _____

Responsible Party Information (if different from patient):

Name (Last, First Middle): _____

Date of Birth: _____ Social Security #: _____ Gender: ___ Male ___ Female

Address: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

Dental Insurance Information:

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Dental History:

How is your dental health? Excellent Good Fair Poor Reason for this appointment: _____

Any specific dental problems we should be aware of: _____

Name of previous dentists: _____

Purpose of your last dental appointment: _____ When was that? _____

When was the last time you had a dental cleaning? _____ Dental x-rays?_____

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

Do you think you have any decay/cavities? Yes No Do you suffer from chronic bad breath or bad taste? Yes No

Do your gums bleed easily when brushing or flossing? Yes No Do you have any jaw joint cracking or pain? Yes No

Dental Treatment Consent:

- I authorize the Dentists(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentists. This Form also authorizes this Practice to submit insurance claim forms and received payment directly from the Insurance Carrier with the notation: “SIGNATURE ON FILE.” I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1.5% per month.

Patient/Guardian Signature: _____ Date: _____

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Patient Medical History

Name (Last, First Middle): _____

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	YES	NO
Heart Murmur*	❑	❑
Mitral Valve Prolapse*	❑	❑
Heart Valve Defect*	❑	❑
Angina	❑	❑
Stroke	❑	❑
Heart Attack	❑	❑
Bypass	❑	❑
Pacemaker	❑	❑
Other Heart Problems	❑	❑
Rheumatic Fever	❑	❑
Artificial Joint	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Anemia	❑	❑
Hemophilia	❑	❑
Sickle Cell Trait	❑	❑
Blood Transfusions	❑	❑
Other Blood Disorders	❑	❑
Do You Smoke	❑	❑
Asthma	❑	❑

	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Sinus Trouble	❑	❑
Breathing Problems	❑	❑
Difficulty Healing	❑	❑
Diabetes	❑	❑
Thyroid Problems	❑	❑
Adrenal/Pituitary Problems	❑	❑
Liver Problems	❑	❑
Hepatitis/Jaundice	❑	❑
Kidney Problems	❑	❑
Stomach Ulcers	❑	❑
Mental Illness	❑	❑
Epilepsy or Seizures	❑	❑
Alcoholism	❑	❑
Drug Abuse	❑	❑
Cancer/Tumor	❑	❑
Other Growths	❑	❑
Chemotherapy	❑	❑

	YES	NO
STD	❑	❑
HIV/AIDS	❑	❑
Other Infectious Disease	❑	❑
Are your pregnant?	❑	❑
Allergic Reaction:		
Penicillin	❑	❑
Erythromycin	❑	❑
Sulfa	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Latex	❑	❑
Local Anesthetic	❑	❑

Allergies to other medications or substances? Please list:

_____

*Do you need to take antibiotic premedication prior to dental appointments? ❑ YES ❑ NO Type: _____

Are you presently taking any prescription or over-the-counter medications? ❑ YES ❑ NO

If so, what medications:

Name: _____ For: _____

Name: _____ For: _____

Name: _____ For: _____

Are you presently being treated by a physician? ❑ YES ❑ NO

If so, physician's name and phone number: _____

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Patient/Guardian Signature: _____ Date: _____

HIPPA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you at the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U. S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon execution of this consent.

_____

Patient Signature Date