Welcome

Patient

Name:_____Soc.Sec.#_____
Last Name First Name Initial

Preferred/Nickname:_____

Home Address:_____ PO BOX: _____

City:_____State:_____Zip_____ Home Phone:_____

Work Phone:_____ Ext._____ Cellular Phone: _____

Birth Date:_____ Drivers Lic:_____ Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Employer:_____ Insurance Company: _____

E-Mail address: _____

Whom can we thank for referring you?_____

Emergency Contact name/# :_____

Primary Insurance/Responsible Party

Subscribers Name:_____
Last Name First Name Initial

Relationship to Patient:_____ Soc.Sec.#_____

Physical Address:_____ PO BOX: _____

City:_____ State:_____Zip_____ Home Phone:_____

Work Phone:_____ Ext._____ Cellular Phone: _____

Birth Date:_____ Drivers Lic:_____ Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Employer:_____ Insurance Company: _____

Secondary Insurance/Responsible Party

Subscriber Name:_____
Last Name First Name Initial

Relationship to Patient:_____ Soc.Sec.#_____

Physical Address:_____ PO BOX: _____

City:_____State:_____Zip_____ Home Phone:_____

Work Phone:_____ Ext._____ Cellular Phone: _____

Birth Date:_____ Drivers Lic:_____ Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Employer:_____ Insurance Company: _____

Acceptable Means of Communication

It is acceptable to discuss health and or billing information by the following means:

- You may leave a information on my home voice mail: ☐(yes), (no) ☐
- You may leave information on my cell phone voice mail ☐(yes, (no) ☐
- You may send me an email ☐(yes), (no) ☐

Special Instructions:_____

It is acceptable to send a text message for the following:

- ☐ Appointment Reminders
- ☐ Continuing Care

It is acceptable to send email messages for the following:

- ☐ Birthday wishes
- ☐ Thank You
- ☐ Continuing Care
- ☐ Appointment Reminders
- ☐ Coupons, Special Announcements

Please List authorized persons with whom we may discuss your Protected Health Information:

Name:_____Phone Number:_____Relationship:_____Info Authorized, i.e. (pick up xrays)_____

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Name:_____ Phone Number:_____Relationship:_____Info Authorized, i.e. (pick up xrays)_____

Name:_____Phone Number:_____Relationship:_____Info Authorized, i.e. (pick up xrays)_____

Name:_____Phone Number:_____Relationship:_____Info Authorized, i.e. (pick up xrays)_____

I authorize Quality Dental to take radiographs, study models, photos, and other diagnostic aids or material as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

I authorize Quality Dental to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

I authorize Quality Dental to submit claims for payment for services rendered or pre authorizations necessary to my insurance company, on my behalf and in my name listed as “signature on file” and assign to Quality Dental the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I hereby authorize, as indicated by my signature below; to use and to disclose my protected health information for any clinical, financial, and insurance purpose, as indicated above.

Patient/Guardian Signature:_____Date:_____

Print Name:_____

Quality Dental PLLC

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____