TRIPLE OAK
DENTAL

NEW PATIENT INFORMATION

Today's Date: _____

First Name: _____ MI: ____ Last: _____

Date of Birth: _____ Age: _____

Gender:
☐ Male
☐ Female
☐ Non-Binary
☐ Prefer Not to Answer

Social Security Number (Optional): _____

CONTACT INFORMATION

Street Address: _____ City: _____
State:_____ Zip Code: _____

Cell Phone: _____Home Phone: _____

Work Phone: _____ Email Address: _____

Preferred Method of Contact:

☐ Text

☐ Phone Call

☐ Email

EMERGENCY CONTACT : Name _____ Relationship to patient: _____

Number: _____

RESPONSIBLE PARTY: Name: _____Relationship to patient:_____

Number: _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company: _____Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber ID Number:_____ Group Number: _____Employer: _____

Secondary Dental Insurance (If Applicable)

Insurance Company: _____Subscriber Name: _____

Subscriber Date Of Birth: _____ Subscriber ID Number: _____

Group Number: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Location: _____

DENTAL INFORMATION

How long has it been since your last dental cleaning?

☐ Less than 6 months ☐ 6–12 months ☐ 1–2 years ☐ Over 2 years ☐ Never

Reason for today's visit: _____

Do you have any dental concerns today? _____

MEDICAL HISTORY

Are you currently under the care of a physician?

☐ Yes ☐ No

If yes, for what? _____

Have you been hospitalized or had surgery within the last 5 years?

☐ Yes ☐ No If yes, explain: _____

MEDICATIONS

Are you currently taking any prescription medications or supplements?

☐ Yes ☐ No

If yes, please list: _____

ALLERGIES

Do you have any allergies? *(Check all that apply.)*

☐ No Known Allergies ☐ Penicillin ☐ Amoxicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Ibuprofen ☐ Latex

☐ Local Anesthetic (Novocaine/Lidocaine) ☐ Metals ☐ Food Allergies ☐ Other:_____

MEDICAL CONDITIONS

Have you ever been diagnosed with any of the following? *(Check all that apply.)*

☐ None

☐ High Blood Pressure ☐ Heart Disease ☐ Heart Murmur ☐ Artificial Heart Valve ☐ Pacemaker ☐ Stroke

☐ Diabetes ☐ Thyroid Disease ☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ Bleeding Disorder ☐ Anemia

☐ Osteoporosis ☐ Arthritis ☐ Kidney Disease ☐ Liver Disease ☐ Hepatitis ☐ Cancer ☐ HIV/AIDS ☐ Anxiety

☐ Depression ☐ Seizures/Epilepsy ☐ Currently pregnant ☐ Other: _____

TOBACCO USE

Do you currently use tobacco or nicotine products?

☐ No ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco ☐ Vape/E-Cigarette ☐ Former User

DENTAL PRECAUTIONS

Have you ever been advised to take antibiotics before dental treatment?

☐ Yes ☐ No

Have you ever had complications with dental treatment or anesthesia?

☐ Yes ☐ No If yes, explain: _____

ADDITIONAL HEALTH INFORMATION

Please list any other medical conditions or concerns we should know before treatment:

_____
_____

PATIENT CERTIFICATION

I certify that the information provided is true and complete to the best of my knowledge. I understand that it is my responsibility to notify Triple Oak Dental of any changes in my health or medications.

Patient Signature: _____

Date: ____ /____ /_____

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Google ☐ Facebook ☐ Instagram ☐ Insurance Provider ☐ Community Event ☐ Mailer

☐ Drive By

☐ Other _____

If referred by someone, we'd love to thank them!

Referred By: _____

COSMETIC DENTISTRY

Are you interested in whitening/cosmetic improvements?

☐ Yes ☐ No ☐ I'd like more information

If yes, what interests you?

☐ Teeth Whitening ☐ Veneers ☐ Invisalign/Clear Aligners ☐ Cosmetic Bonding ☐ Smile Makeover

☐ Other _____

PATIENT ACKNOWLEDGEMENT:

I certify that the information provided on this form is true and complete to the best of my knowledge. I authorize Triple Oak Dental to provide necessary dental treatment and to bill my insurance carrier when applicable. I understand that I am financially responsible for charges not covered by my insurance.

Patient/Guardian Signature: _____Printed Name: _____ Date: _____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

At **Triple Oak Dental**, we are committed to protecting the privacy and confidentiality of your health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).Our **Notice of Privacy Practices** explains how your protected health information may be used and disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law. It also describes your rights regarding your health information.By signing below, you acknowledge that you have been given the opportunity to review or receive a copy of Triple Oak Dental's Notice of Privacy Practices.Your signature only acknowledges receipt of the Notice of Privacy Practices. It does **not** mean that you have waived any of your rights under HIPAA.

Patient/Guardian Signature: _____ Printed Name: _____ Date: _____