New Patient Form

Patient Information:

Patient Name: _____ Today's Date: ____/____/_____

Birthdate: ____/____/_____ Age: _____ SS#: _____

Mailing Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Ext.: _____ Email: _____

Employer: _____ How Long: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Children: Y / N If yes, how many: ____

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

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Emergency Contact

Name: _____ Relation: _____

Home Phone: (____) _____ Cell Phone : (____) _____

Who is your medical doctor? _____

Medical doctor's phone number: (____) _____

Insurance Information:

Primary Dental Insurance:

Company Name: _____

Company Address: _____ Company Phone: (_____)_____

City: _____ State: _____ Zip: _____

Insured's ID: _____ Group Number: _____

Insured's Name: _____ Relationship: _____

Secondary Dental Insurance:

Company Name: _____

Company Address: _____ Company Phone: (_____)_____

City: _____ State: _____ Zip: _____

Insured's ID: _____ Group Number: _____

Insured's Name: _____ Relationship: _____

Account Responsibility:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ SS#: _____ DL#: _____

Payment Method: ☐Cash ☐Check ☐ Credit card: _____Exp._____

_____ I hereby authorize the assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

DENTAL INFORMATION

Reason for today's visit:
☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate if any of the following problems apply:

☐ Discomfort, clicking or popping in jaw
☐ Blisters / sores in or around the mouth
☐ Red, swollen or bleeding gums
☐ Loose / broken filling(s)
☐ Teeth grinding
☐ Ringing in ears
☐ Stained teeth
☐ Locking jaw
☐ Bad breath
☐ Broken / chipped tooth
☐ Sensitive teeth, teeth or gums
☐ Active decay / cavity(ies)
☐ Other:
_____
_____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Have you ever been treated for Gum Disease? ☐ Yes ☐ No

Previous Dentist:
Name: _____
Address: _____
Phone: _____

Last Dental Exam: ____ / ____ / _____
Last Dental X-rays: ____ / ____ / _____
Last Dental Cleaning: ____ / ____ / _____

Have you had problems with previous dental treatment? ☐ Yes ☐ No
If so, explain: _____

Times a day you brush: _____
Times a week you floss: _____
Type of toothbrush bristles: ☐ Soft ☐ Medium ☐ Hard
Rate your smile from 1–10: _____
Would you like whiter teeth? ☐ Yes ☐ No
Have you had orthodontic treatment? ☐ Yes ☐ No
Things you would change about your smile: _____

MEDICAL HISTORY & INFORMATION

What medications are you taking? (Check all that apply)

☐ Nerve pills
☐ Pain killers (including aspirin)
☐ Muscle relaxers
☐ Stimulants
☐ Blood thinners
☐ Tranquilizers
☐ Insulin
☐ Meds for Osteoporosis
☐ Vitamins / Supplements
☐ Other(s), please list:
_____

Have you ever taken Bisphosphonates (ex: Aredia / Fosamax)? ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions, or procedures? (Check Y or N)

Heart / Circulatory:
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Attack / Stroke
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Heart Disease / Angina
☐ Y ☐ N Pacemaker

Respiratory:
☐ Y ☐ N Lung Disease
☐ Y ☐ N Asthma
☐ Y ☐ N Emphysema
☐ Y ☐ N Tuberculosis

Endocrine / Metabolic:
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Diabetes
☐ Y ☐ N Hypoglycemia

For women:
Are you taking Birth Control pills? ☐ Yes ☐ No
Are you taking Hormone replacement? ☐ Yes ☐ No
Are you Pregnant? ☐ No ☐ Yes How long? _____
Are you nursing? ☐ Yes ☐ No

Please rate your general health from 1–10: _____

Do you wear contact lenses? ☐ Yes ☐ No

How many children have you had? _____

Neurological / Mental Health:
☐ Y ☐ N Seizures / Epilepsy
☐ Y ☐ N Dizziness / Fainting
☐ Y ☐ N Headaches
☐ Y ☐ N Depression / Anxiety

Gastrointestinal:
☐ Y ☐ N Ulcers
☐ Y ☐ N Acid Reflux
☐ Y ☐ N Liver Disease

Blood / Immune:
☐ Y ☐ N Anemia
☐ Y ☐ N Bleeding Problems
☐ Y ☐ N HIV / AIDS
☐ Y ☐ N Hepatitis

Musculoskeletal / Other:
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Joints / Implants
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Cancer / Tumors / Growths
☐ Y ☐ N Nervous Disorders

Please list any other surgeries or medical conditions you have or ever had:
_____

Are you allergic to any of the following?
☐ Latex
☐ Penicillin / Amoxicillin
☐ Tetracycline
☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Foods
☐ Other(s):
_____

Do you use tobacco? ☐ No ☐ Yes

How/how often? _____

Signature: _____ Date: ____ / ____ / _____
☐ Adult Patient ☐ Parent / Guardian ☐ Spouse

PATIENT CONSENT & AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please Print

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Telephone Number: (_____)_____E-mail Address:_____

PATIENT AUTHORIZATION
I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:
_____
_____

I hereby authorize LAKE CITY FAMILY DENTISTRY to release the above-described information to:

_____
(Name of individual(s) and/or organization receiving information)

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

LAKE CITY FAMILY DENTISTRY

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

PATIENT OR PERSONAL REPRESENTATIVE

Signature: _____ Date: _____
Name: _____
(Please Print)
Relationship to Patient: _____

FOR OFFICE USE ONLY

Received by: _____ Date: _____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

☐ How this office will use and disclose my protected health information.
☐ My privacy rights with regard to my protected health information.
☐ This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

LAKE CITY FAMILY DENTISTRY
804 West Main Street
Lake City, SC 29560

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____

Name: _____
(Please Print)

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of receipt of our Notice of Privacy Practices. Despite these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal): _____
☐ Communications barriers prohibited obtaining an acknowledgment.
☐ An emergency situation prevented us from obtaining an acknowledgment.
☐ Other: _____

Attempt was made by: _____ Date: _____