Artistic Dentistry Medical/Dental History

Please Complete the Following *Confidential* Medical/Dental History Information

Patient Name: ______________________ **Date:** ______________

Primary Care Physician: ______________________ Dr. Phone #: ______________

Medical Specialist: ______________________ Dr. Phone #: ______________

Preferred Pharmacy/Location: ______________________________

Are you under ongoing Medical Care now? **YES** **NO** For What Condition? ______________

Any Surgery/Hospital visit in the last 3 years? **YES** **NO** Please explain Procedures/Conditions:

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Do you take an **antibiotic pre-medication** prior to dental visits? **YES** **NO** Name of Medication ______________

Please List ALL **Medications/Supplements** you currently take: ______________________________

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Have you ever taken Bone Density Drugs? (Fosamax, Boniva, etc) **YES** **NO** Drug Name/How Long? ______________

Please **circle** any medications/materials you are **Allergic** to? Anesthetics Latex Penicillin Sulfa Aspirin Metals Codeine

List any ALL other **Allergies**: ______________________________

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Do you use tobacco and/or controlled substances? If yes, list type and frequency ______________________________

Please circle YES or NO for *each item* that you have now or have had before:

YES **NO** Abnormal Bleeding	**YES** **NO** Emphysema	**YES** **NO** Liver Disease	**YES** **NO** Neck/Jaw Injury
YES **NO** AIDS/HIV Positive	**YES** **NO** Epilepsy / Seizures	**YES** **NO** Low Blood Pressure	**YES** **NO** Clench / Grind Teeth
YES **NO** Alzheimers	**YES** **NO** Fainting / Dizziness	**YES** **NO** Lung Disease	**YES** **NO** Jaw Click / Pop
YES **NO** Anemia	**YES** **NO** Glaucoma	**YES** **NO** Mitral Valve Prolapse	**YES** **NO** Bleeding Gums
YES **NO** Angina	**YES** **NO** Heart Attack / Failure	**YES** **NO** Osteoporosis	**YES** **NO** Frequent Headaches
YES **NO** Arthritis/Gout	**YES** **NO** Heart Disease	**YES** **NO** Psychiatric Care	**YES** **NO** Orthodontic Treatment
YES **NO** Artificial Joint / Bone	**YES** **NO** Heart Murmur	**YES** **NO** Rheumatic Fever	
YES **NO** Asthma	**YES** **NO** Heart Pacemaker	**YES** **NO** Shingles	**WOMEN ONLY, Are you currently:**
YES **NO** Blood Disease	**YES** **NO** Heart Surgery	**YES** **NO** Sickle Cell Disease	**YES** **NO** Pregnant
YES **NO** Bruise Easily	**YES** **NO** Heart Valves (Artificial)	**YES** **NO** Sinus Problems	**YES** **NO** Nursing
YES **NO** COPD	**YES** **NO** Hemophelia	**YES** **NO** Stomach Disease	**YES** **NO** Taking Birth Control
YES **NO** Cancer ________	**YES** **NO** Hepatitis Type____	**YES** **NO** Stroke	
YES **NO** Chemo / Radiation	**YES** **NO** High Blood Pressure	**YES** **NO** Substance Abuse	Any Condition Not Listed:
YES **NO** Chest Pains	**YES** **NO** High Cholesterol	**YES** **NO** Swelling of Limbs	
YES **NO** Cold Sores	**YES** **NO** Hypoglycemia	**YES** **NO** Thyroid Problems	______________
YES **NO** Colitits	**YES** **NO** Jaundice	**YES** **NO** Tuberculosis	
YES **NO** Diabetes	**YES** **NO** Kidney Problems	**YES** **NO** Ulcers	______________

Do you wear dentures or partials? **YES** **NO** Upper - How Long? ________ Lower - How Long? ________

Have you had regular dental care? **YES** **NO** Date of Last Visit to Dentist? ______________

Do you have dental pain / problems today? **YES** **NO** Please Describe: ______________

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Please inform us of any special needs during dental treatment: ______________________________

Signature of Patient (If patient is a minor, Signature of Guardian)	Date

Welcome To Artistic Dentistry

*Please Complete the Following **Confidential** Patient Registration Information*

Patient Name ______________________ **Name you prefer to be called:** ______________

First MI Last

Home Address ______________________

City, State, Zip ______________________

Home Phone ______________ **Work Phone** ______________ **Cell** ______________

Birthdate ______________ **Please Circle** Male Female

Social Security # ______________ Single Married Divorced Widowed Other

Whom may we Thank for Referring You? ______________ **Spouse's Name** ______________

Person to Contact in Case of Emergency? ______________ **Contact Phone** ______________

Preferred Pharmacy & Cross Streets: ______________ **Phone** ______________

*Please Complete the Following **Confidential** Contact Information*

Email Address ______________________

Please circle your contact preference: Home Ph. (call,voicemail) Cell Ph (call,voicemail) Email Text

Please indicate any Person with whom you give us permission to discuss your Dental Treatment, Appointments or Fees:

Name ______________ Phone ______________ Relation ______________

*If you Have **Dental Insurance,** Please Complete the Following Information*

Name of Insured ______________ Relationship to Patient ______________

Social Security or ID # of Insured ______________ Birthdate of Insured ______________

Employer or Group Name ______________ Group Number ______________

Insurance Company Name ______________ Insurance Phone # ______________

******If you have coverage with more than one Dental Insurance Company, Please let us know.******

*Please read and sign below to acknowledge your **HIPAA** rights*

My signature below indicates that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I acknowledge that I have been offered a copy of the Federal HIPAA guidelines.

Printed Name ______________________ **Date** ______________

Signature ______________________

*Please read and sign below for **Authorization, Release, and Agreement to Pay for Services***

I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior financing has been made. I agree to pay a billing fee, if balance is not paid within 35 days of the monthly billing date. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I authorize this office to leave messages and/or mail correspondence to remind me of upcoming appointments. I understand that a broken appointment fee of $35.00 may be charged to my account if I miss an appointment or cancel with less than 48 hours notice.

Signature ______________________________ **Date** ______________