# REED DENTAL CARE

"See Dr. Reed for every dental need."

## PATIENT INFORMATION

Date

Patient Last Name | First | Middle Initial

Street Address | City | State | Zip

E-mail Address | Sex | Age | Date of Birth

Patient Employer/School | Occupation

Employer/School Address | Employer/School Phone

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Minor ☐ Partnered for __ years

Spouse's Name | Date of Birth | SS# | Spouse's Employer

Home Phone | Work Phone | Cell Phone

Spouse's Work Phone | Best time and place to reach you

## EMERGENCY CONTACT

Name | Relationship

Home Phone | Work Phone

## DENTAL INSURANCE

Who is responsible for this account? | Relationship to Patient

Insurance Company | Group#

Is patient covered by additional insurance? ☐ Yes ☐ No

Subsciber's Name | Date of Birth | SS# | Relationship to Patient

Insurance Company | Group#

ASSIGNMENT & RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ees) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative | Printed name of Patient, Parent, Guardian or Personal Representative

Date | Relationship to Patient

# DENTAL & MEDICAL HISTORY

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 pertaining both your dental and medical history.

Reason for today's visit

Former Dentist

City/State

Date of last dental visit

Date of last dental X-rays

## PLEASE MARK "YES" OR "NO" TO INDICIATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- Y N Bad breath
- Y N Bleeding gums
- Y N Blisters on lips or mouth
- Y N Burning sensation on tongue
- Y N Chew on one side of mouth
- Y N Cigarette, pipe or cigar smoking
- Y N Clicking or popping jaw
- Y N Dry mouth
- Y N Fingernail biting
- Y N Food collection between teeth
- Y N Foreign objects
- Y N Grinding teeth
- Y N Gums swollen or tender
- Y N Jaw pain or tiredness
- Y N Lip or cheek biting
- Y N Loose teeth or broken fillings
- Y N Mouth breathing
- Y N Mouth pain, brushing
- Y N Orthodontic treatment
- Y N Pain around ear
- Y N Periodontal treatment
- Y N Sensitivity to cold
- Y N Sensitivity to heat
- Y N Sensitivity to sweets
- Y N Sensitivity when biting
- Y N Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Women: Are you ☐Pregnant/trying ☐Nursing ☐Taking oral contraceptives

Are you allergic to any of the following: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics ☐Other

If yes: _____

Are you under a physician's care now? Y N

If yes: _____

Have you ever been hospitalized or had a major operation? Y N

If yes: _____

Have you ever had a serious head or neck injury? Y N

If yes: _____

Are you taking any pills, medication or drugs? Y N

If yes: _____

Do you take, or have you taken, Phen-Fen or Redux? Y N

If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Y N

If yes: _____

Are you on a special diet? Y N

Do you use tobacco? Y N

Do you use controlled substances? Y N

If yes: _____

## DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

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

Have you ever had any serious illness not listed above? Y N If yes: _____

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 medial status.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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# NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT & PATIENT CONSENT FORM

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health/dental information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
- Conduct normal healthcare operations, such as physician certifications and assessments.
- Obtain payment from third party payers, such as insurance companies.
- Confirm and leave messages at phone numbers provided to this office.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at anytime to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or dental care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient Name

_____

Relationship to Patient

_____

_____

_____

Additional family members granted acess

_____ _____

Signature Date