# WELCOME

**The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.**

## 1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

**Name:** _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

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

**Home Address:** _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: (____) _____

Wk #: (____)_____ Ext: ____ DL #: _____

**Employer:** _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

## 2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

**Person Responsible for Account:** _____

Contact #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

## 3 INSURANCE

### Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

### Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

### Neighbor or Relative not living with you (for emergency).

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

## 4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

## 4 MEDICAL HISTORY CONTINUED

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

**For Women:** Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases or medical problems**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Herpes / Fever Blisters |
| Y | N | Alcohol / Drug Abuse | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | HIV$^+$ / AIDS |
| Y | N | Arthritis | Y | N | Hospitalized for Any Reason |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Kidney Problems |
| Y | N | Asthma | Y | N | Liver Disease |
| Y | N | Blood Transfusion | Y | N | Low Blood Pressure |
| Y | N | Cancer / Chemotherapy | Y | N | Lupus |
| Y | N | Colitis | Y | N | Mitral Valve Prolapse |
| Y | N | Congenital Heart Defect | Y | N | Osteoporosis / Paget's Disease |
| Y | N | Diabetes | Y | N | Pacemaker |
| Y | N | Difficulty Breathing | Y | N | Psychiatric Treatment |
| Y | N | Emphysema | Y | N | Radiation Treatment |
| Y | N | Epilepsy | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Fainting Spells | Y | N | Seizures |
| Y | N | Frequent Headaches | Y | N | Shingles |
| Y | N | Glaucoma | Y | N | Sickle Cell Disease / Traits |
| Y | N | Hay Fever | Y | N | Sinus Problems |
| Y | N | Heart Attack | Y | N | Stroke |
| Y | N | Heart Murmur | Y | N | Thyroid Problems |
| Y | N | Heart Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Hemophilia | Y | N | Ulcers |
| Y | N | Hepatitis | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

_____

_____

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Tetracycline |
| Y | N | Codeine | Y | N | Latex | Y | N | Other |
| Y | N | Dental Anesthetics | Y | N | Penicillin | | | |

Please list any other drugs/materials that you are allergic to: _____

_____

## 5 DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

**Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No**

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

**Payment is due in full at the time of treatment**
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

**Doctor's Comments:** _____

_____

### MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

Mountainside
Dental Care

# JOSHUA CROSBY, D.D.S.
# ERIC HARTVIGSEN, D.D.S.
# MICHAEL HAYMORE, D.D.S.

## PATIENT AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

**You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.**

**Date:** _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITYS IN THE FUTURE.**

_____ Please **print** your name

_____ Please **sign** your name

_____ Legal Representative

_____ Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Initial: _____

Name: _____ Relationship: _____ Initial: _____

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

___ Cell Phone Confirmation
___ Home Phone Confirmation
___ Work Phone Confirmation
___ Text Message to my Cell Phone
___ Email Confirmation
Email: _____
___ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

___ Cell Phone Confirmation
___ Home Phone Confirmation
___ Work Phone Confirmation
___ Text Message to my Cell Phone
___ Email Confirmation
___ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to maintaining and/or improving oral health care.