DENTRICITY
DENTAL SPECIALTY

Welcome to Our Practice

Please complete the following:
Patient Information • Insurance Information & Financial Consent
HIPPA Compliance • Health and Medical History • Advanced Diagnostics and Informed Consent

Patient Information

Name _____ Today's Date _____

E-mail _____ Date of Birth _____ Age _____ Sex _____

Address _____ Phone (h) _____ SS#

City _____ State _____ Zip _____ Phone (c) _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Pharmacy Name _____ Pharmacy Phone # _____

Referring General Dentist Information

Office Name _____ Date of Last Visit _____

Dentist Name _____ Reason of Referral _____

City _____ State _____ Zip _____ Office Phone Number _____

Insurance Information & Financial Consent

Dental Insurance

Primary Company _____ Policy Holder _____

Member ID # _____ Relationship _____ Employer _____

Group # _____ Date of Birth _____ SS# _____

Secondary Company _____ Policy Holder _____

Member ID # _____ Relationship _____ Employer _____

Group # _____ Date of Birth _____ SS# _____

Financial Consent

An approximated fee is required at the time of service. Verification of insurance benefits is always an estimate and never a guaranteed amount, as remaining dental maximums can be affected daily by multiple claims and providers. After treatment is complete, we will file an insurance claim as a courtesy for you. If for any reason your insurance does not pay what is expected, you will be financially responsible.

_____ _____

Signature Date

HIPPA Consent

By signing below you are giving us consent to confirm appointments, disclose dental information requested by other treating dentists, leave messages/discuss medical or dental history with your pharmacist, request dental information from your insurance company, and/or request dental records when necessary and leave messages regarding your dental insurance. We are required by law to maintain the privacy of protected health information and provide individuals with a copy of our HIPPA compliance notice at the patient's request.

_____ _____

Signature Date

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Medical Health History

Please answer ALL questions honestly and completely. All YES/NO questions must be answered.

HEIGHT_____**WEIGHT** _____

LIST ALL SURGERIES AND DATES

_____

_____

Any problems with anesthesia in the past? ◯ Yes ◯ No

Have you ever had a serious illness or hospitalization? ◯ Yes ◯ No

When was your last medical check-up and for what purpose?

_____

Primary Physician's Name_____ Phone # _____

Address _____

Drug Allergies ◯ Yes ◯ No Pls list_____ Latex Allergy ◯ Yes ◯ No

PLEASE LIST ALL OF YOUR MEDICATIONS (INCLUDE CHRONIC PAIN MEDICATION, INSULIN, ASPIRIN, BIRTH CONTROL, BLOOD THINNERS, ETC.)

_____ _____ _____ _____

_____ _____ _____ _____

Check YES or NO on ALL of the following conditions which you have had in the past or you have right now.

	Yes	No
Blood Transfusion	☐	☐
Heart Attack/Problems	☐	☐
Physical Disability	☐	☐
High Blood Pressure	☐	☐
Pain in Jaw Joints	☐	☐
Recreational Drugs	☐	☐
Mitral Valve Prolapse	☐	☐
Bacterial Endocarditis	☐	☐
Heart Pacemaker	☐	☐
Radiation Therapy	☐	☐
Bleeding/ Bruise easily	☐	☐
Chronis Steroid Meds	☐	☐
Kidney Problems	☐	☐
Pregnant or Trying	☐	☐
Gagging w/ Dental Work	☐	☐
Rheumatism/ Arthritis	☐	☐

	Yes	No
CPAP At Home	☐	☐
Liver Disease	☐	☐
Heart Murmur	☐	☐
Fainting	☐	☐
COPD	☐	☐
Sinus Trouble	☐	☐
HIV/AIDS	☐	☐
Thyroid Disease	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
Home Oxygen	☐	☐
Chronic Pain	☐	☐
Organ	☐	☐
Transplant	☐	☐
Mouth Pain	☐	☐
Tuberculosis	☐	☐

	Yes	No
Heart Surgery? *When?* _____	☐	☐
Artificial Joints *When/Which joint?* _____	☐	☐
Hepatitis *What type?*____ *Treatment?*____	☐	☐
Angina/Chest pain *When/How often?* _____	☐	☐
Cancer *Type/Location* _____	☐	☐
Shortness of Breath *When?* _____	☐	☐
Alcohol/Recreation/Drug Abuse *Drug* _____	☐	☐
Stroke? *When* _____	☐	☐
Diabetes *Type 1 Type 2* Insulin ◯ Yes ◯ No	☐	☐
Asthma How often do you need to use your inhaler ____	☐	☐
Seizures *Type*_____ *Last seizure*_____	☐	☐
Irregular Heart Beat *What type* _____	☐	☐
Low Bone Density/Osteoporosis *Medication?*____	☐	☐
Psychiatric/Mental *Illness Type?*_____	☐	☐
Chemotherapy *Why/When?* _____	☐	☐
Headaches/Migraines *How Often?*_____	☐	☐

Please list ALL medical problems not mentioned above _____

_____

_____

By signing below, I (patient or guardian) attest that I have given a complete and truthful medical history.

_____ Signature

_____ Date