Delray Dental

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PATIENT INFORMATION

Patient Name: _____ **Preferred Name:** _____

Gender: MALE FEMALE OTHER **Marital Status:** Single Married Divorced Other _____

Date of Birth: ____/_____/_____ **Social Security #:** _____ **Driver's License #:** _____

Address: _____ **City:** _____ **State:**_____ **Zip:** _____

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

Email Address: _____ **Contact Method Preferred:** _____

Employer: _____

Emergency Contact: _____ **Relationship:** _____ **Phone**: _____

Other Family Members seen by us: _____

How did you hear about us? _____

If you were referred by someone, whom may we thank for the referral? _____

Preferred day for appointments: _____ **Time:** _____ AM PM

Parent/Guardian Information (*If patient is a minor*):

Name: _____ **Relationship to Patient:** _____

Birth Date: _____/_____/_____ **Home Phone #:** _____ **Cell Phone #:**_____

Address: _____ **City:** _____ **State:**_____ **Zip:** _____

DENTAL INSURANCE INFORMATION

Policyholder's Name: _____ **DOB:** _____/_____/_____ **SSN:** _____

Insurance Company: _____ **Group #:** _____

Employer: _____ **Policyholder's ID #**: _____

Patient Relationship to Policy Holder: SELF SPOUSE CHILD OTHER _____

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DENTAL HISTORY

Date of last dental visit? _____ **Date of last dental X -rays?** _____

How often do you brush? _____ **How often do you floss?** _____

What brings you to our office? _____

Are you currently in pain? YES NO **Do your gums bleed?** YES NO

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? YES NO

Have you ever had problems with previous dental treatment? YES NO

If yes, please explain: _____

Do you have dental anxiety? YES NO **Do you have sensitivity to:** COLD HOT SWEETS BITING NONE

Do you have or have had any of the following:
Dentures or Partial Dentures Dental Implants Orthodontic Treatment Fillings NONE

Do you smoke or use chewing tobacco? YES NO **If yes, how long?** _____ **How often?** _____

MEDICAL HISTORY

Physician's Name: _____ **Phone:** _____ **Date of Last Visit:** _____

Have you ever had a serious head, neck, or back injury? YES NO **If YES, describe:** _____
Are you currently under medical treatment? YES NO
Any serious illnesses/operations in the past 5 years? YES NO **If YES, describe:** _____

WOMEN ONLY: Are you or could you be pregnant? YES NO
WOMEN ONLY: Are you nursing? YES NO
WOMEN ONLY: Are you taking oral contraceptives? YES NO

Are you currently being treated for or have you ever been treated for any of the following? Check all that apply:

Rheumatic Fever	Epilepsy/Seizures	Tuberculosis	Hepatitis	Low Blood Pressure
Heart Murmur	Diabetes	Asthma	HIV/AIDS	High Blood Pressure
Mitral Valve Prolapse	Glaucoma	Sinus Problems	Heart Attack/Stroke	Blood Transfusion
Artificial Valve/Stent	Arthritis	Cancer/Chemo	Pacemaker	Drug/Alcohol Abuse
Implant/Transplant	Kidney Problems	Severe Headaches	Psychiatric Care	Autism
Thyroid Problems	Heart Surgery	Excessive Bleeding/Bruise Easily		

Please list any medical condition(s) not listed above: _____

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MEDICAL HISTORY CONTINUED

Are you allergic to any of the following? Please check all that apply:

Latex	Penicillin	Aspirin	Erythromycin	Codeine
Tetracycline	Ibuprofen (Advil/Motrin)	Tylenol	Sulfa	Dental Anesthetics

Other:_____

Please list all medications you are currently taking, including over the counter and supplements: _____

_____

Are you taking blood thinners (Xarelto, Coumadin/Warfarin, Eliquis)? YES NO

Have you ever taken Oral Bisphosphonates (Fosamax, Boniva) or IV Bisphosphonates (Zometa, Aredia)? YES NO

PREFERRED PHARMACY

Name: _____ **Phone Number:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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 that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature:_____ **Date:** _____

Parent/Guardian Signature:_____ **Date:** _____
(if patient is a minor)

Missed Appointments/Short Notice Cancellations:

$25 cancellation fee will be applied to missed or cancelled appointments without 24 hours in advanced notice. _____ (Patient Initials)

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Notice of Privacy Practices:

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:
We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We will change this notice and make the new notice available upon request. You may request a copy at any time. You may contact us to request more information about our privacy practice.

USES AND DISCLOSURES OF HEALTH INFORMATION:
We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

Signature: _____ **Date:** _____

HIPAA COMPLIANCE:

In compliance with the federal HIPAA policy, we are requesting your permission to send out appointment reminders via postcards to the address on file. These postcards will have your name, address, time, and date of your appointment viewable by the United States Postal Service.

I give Delray Dental permission to send appointment reminders via postcards.

Patient Signature: _____ **Date:** _____