Patient Information (CONFIDENTIAL)

How did you hear about us?_____

Neighborhood Dental can now confirm appointments by Email or Text. Please check your preference: ❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you willing to be on a quick-fill list? ❑ Yes ❑ No

Patients receive a 10% discount off treatment or $20 credit for routine exam/cleaning when taking a quick-fill appointment. You may receive numerous phone calls when there are cancellations.

Are you interested in our in-house payment program through Care Credit?

❑ Yes ❑ No

Neighborhood Dental

❑ Check this box if you agree to receive commercial electronic messages from Neighborhood Dental. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

Name _____ Birthdate _____ Home Phone _____ ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Email _____ SS#_____ Cell Phone _____

If Full Time Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Emergency Contact _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#_____

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease?_____

_____

2. Do you like your smile? _____ How would you rate your smile on a scale from 1-10?_____

3. What changes would you make to improve your smile?_____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

Over Please...

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain: _____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking?		
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	❑	❑
If yes, for what reason? _____		
5. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
_____		
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (Please list)	❑	❑
_____		
_____		
6. Sleep		
a) Have you been told/know you snore?	❑	❑
b) Do you have trouble sleeping?	❑	❑
c) Do you clench or grind your teeth?	❑	❑
d) Do you have sleep apnea?	❑	❑

	Yes	No
7. Do you use tobacco?	❑	❑
8. Do you use controlled substances?	❑	❑
9. **Are you taking any blood thinners?**	❑	❑
10. **Are you taking any bone strengthening medications (bisphosphonates)?**	❑	❑
11. Do you have Hepatitis or Jaundice?	❑	❑
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑
13. Do you have or have you had any of the following?		

	Yes	No
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Type: _____		
Cardiac Pacemaker	❑	❑
Diabetes	❑	❑
Type: _____		
Emphysema	❑	❑
Epilepsy/Convulsions	❑	❑
Fainting/Seizures	❑	❑
Heart Attack	❑	❑
Date: _____		
Heart Disease	❑	❑
Heart Murmur	❑	❑
Heart Trouble	❑	❑
High Blood Pressure	❑	❑

	Yes	No
Joint Replacement or Implant	❑	❑
Date: _____		
Kidney Disease	❑	❑
Leukemia	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Mitral Valve Prolapse	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Rheumatic Fever	❑	❑
Stroke	❑	❑
Date: _____		
Thyroid Problem	❑	❑
Tuberculosis	❑	❑
Other (please list)	❑	❑
_____		
_____		

	Yes	No
14. Women Only:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

HIPAA Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date_____

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following: _____

_____

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date_____