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

☐ Yes ☐ No

Neighborhood Dental

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. Have you ever been told that you snore? _____
3. Do you like your smile? _____ How would you rate your smile on a scale from 1-10? _____
4. 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

Printed Name: _____

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)	☐	☐
_____		
_____		

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

12. 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	☐	☐
Type: _____		
Heart Murmur	☐	☐
High Blood Pressure	☐	☐

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

13. 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_____