

WELCOME TO OUR OFFICE

TODAY'S DATE: _____

PATIENT INFORMATION:

NAME: _____ BIRTH DATE: _____ SS#: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE#: _____ CELL #: _____ WORK#: _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____ REFERRED BY: _____

EMERGENCY CONTACT: _____
NAME HOME # ALTERNATE #

SPOUSE INFORMATION:

SPOUSE'S NAME: _____ OCCUPATION: _____

EMPLOYER: _____ WORK#: _____ EXT: _____

ACCOUNT INFORMATION:

PRIMARY DENTAL INSURANCE COMPANY: _____

GROUP#: _____

CLAIMS ADDRESS: _____ TOLL FREE#: _____
STREET CITY STATE ZIP

PRIMARY SUBSCRIBER INFORMATION:

NAME: _____ BIRTH DATE: _____ SS#: _____
LAST FIRST MI

MEMBER ID#: _____ EMPLOYER: _____

OCCUPATION: _____ WORK#: _____ EXT: _____ HOME#: _____

HOME ADDRESS: _____
STREET CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY: _____

GROUP#: _____

CLAIMS ADDRESS: _____ TOLL FREE#: _____
STREET CITY STATE ZIP

SECONDARY SUBSCRIBER INFORMATION:

NAME: _____ BIRTH DATE: _____ SS#: _____
LAST FIRST MI

MEMBER ID#: _____ EMPLOYER: _____

OCCUPATION: _____ WORK#: _____ EXT: _____ HOME#: _____

HOME ADDRESS: _____
STREET CITY STATE ZIP

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: SELF SPOUSE MOM DAD OTHER

NAME: _____ BIRTH DATE: _____ SS#: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE#: _____ CELL#: _____ WORK#: _____ EXT: _____

EMPLOYER: _____ OCCUPATION: _____

HEALTH HISTORY

1. Do you have pain from any area of your mouth? YES NO If yes, where? _____
2. Are you in good health? YES NO
3. Your last physical examination was on _____
4. Are you now under the care of a physician? YES NO
 - a. Physician's name and phone number: _____
5. Have you been hospitalized or had a serious illness within the past 5 years? YES NO
 - a. If yes, explain: _____
6. Are you now taking any medication drugs or pills? YES NO
 - a. If yes, please list those drugs/reasons: _____
7. Are you allergic or have you reacted to any of the following medications (please check if yes)

Nitrous Oxide <input type="checkbox"/>	Nembutal/Seconal <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Aspirin <input type="checkbox"/>	Erythromycin <input type="checkbox"/>	Percodan <input type="checkbox"/>
Scopolamine <input type="checkbox"/>	Tetracycline <input type="checkbox"/>	Darvon <input type="checkbox"/>	Codeine <input type="checkbox"/>	Demerol <input type="checkbox"/>	Valium <input type="checkbox"/>
Sleeping Pills <input type="checkbox"/>	Novacaine or Xylocaine <input type="checkbox"/>	Other Antibiotics: _____			
Metals: _____		Other: _____			

8. Have you ever had (please check if yes):

Heart Trouble <input type="checkbox"/>	Pacemaker <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Anemia <input type="checkbox"/>	Glaucoma <input type="checkbox"/>
Heart Attack <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Tumor/Cancer <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Asthma <input type="checkbox"/>	Arthritis <input type="checkbox"/>
Heart Murmur <input type="checkbox"/>	Bleeding Problems <input type="checkbox"/>	Venereal Disease <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Jaundice <input type="checkbox"/>
Rheumatic Fever <input type="checkbox"/>	Stomach Problems <input type="checkbox"/>	X-ray Treatment <input type="checkbox"/>	Stroke <input type="checkbox"/>	Ulcers <input type="checkbox"/>	AIDS/HIV <input type="checkbox"/>

9. Do you get up often at night to urinate? YES NO
10. Are you thirsty much of the time? YES NO
11. Has anyone in your family had diabetes? YES NO
12. Do you smoke? YES NO How Much? _____
13. Do you consider yourself a nervous person? YES NO
14. Do you take bisphosphonates? YES NO
15. Do you have any disease, condition, or problem not listed above that you think we should know about? YES NO
 - a. If yes, explain: _____
16. FOR WOMEN ONLY: Are you pregnant? YES NO If yes, what month? _____

CONSENT:

I, the undersigned, hereby authorize Doctor to take radiographs, study models, photographs, or any diagnostic aides deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor with my verbal consent to perform any and all forms of treatment, medication, and therapy after he explains the condition in connection with (name of patient) _____, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that use of anesthetic agents embodies risk. I understand that responsibility for **payment** for dental services provided in this office for myself and/or my dependants is mine, **due and payable at the time services are rendered**. If I do not pay the full balance at the time of service and/or have made financial arrangements for the balance, I understand that a 1.5% finance charge per month (18% annually) will be added to any balance over 90 days. **Furthermore, I understand that a cancellation fee will be charged unless 48 working hours notice is given for appointment changes.**

Signature: _____ Date: _____ Relationship to Patient: _____

IN OFFICE USE ONLY

Health History Reviewed by: _____

Health History Update

CHANGES	DATE	PROVIDER'S SIGNATURE

DENTAL HISTORY

Patient Name (please print) _____ Date: _____

Chief complaint or purpose of this appointment: _____

Date of last dental visit: _____ Purpose: _____

Date of last dental cleaning: _____

Date of last full mouth series of X-rays: _____

Name of previous Dentist: _____ City: _____

	<u>Yes</u>	<u>No</u>
Are any of your teeth sensitive to:	<input type="checkbox"/>	<input type="checkbox"/>
Cold?	<input type="checkbox"/>	<input type="checkbox"/>
Heat?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
When chewing, do you avoid one side?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, Which? _____

Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a soft toothbrush?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use dental floss?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, How Often? _____

Does the floss catch or tear?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, Where? _____

Do you have an unpleasant odor or taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth feel loose?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, Which? _____

Do you ever awaken with pain near your ears or jaw muscles?	<input type="checkbox"/>	<input type="checkbox"/>
Do you hear clicking or popping when you chew?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have	<input type="checkbox"/>	<input type="checkbox"/>
you ever been treated for a bad bite?	<input type="checkbox"/>	<input type="checkbox"/>

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Jeffrey C. Derickson, D.D.S.
762 N. Country Club Rd.
Tucson, AZ 85716
Phone: 327-5993 / Fax: 327-0907

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other