DENTAL PARK
WE MAKE SMILES

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

PATIENT INFORMATION: ***Please sign footer when completed.***

Name:_____DOB:_____Ph#_____
Address:_____City,State,Zip:_____
E-mail:_____Secondary Ph#:_____
Sex: M____F____ Marital Status: Married:____Widowed___Single___Divorced____Seperated____Minor____
Employer/School:_____Employer/School#_____
SS#:_____Whom may we thank for referring you?_____
Emergency Contact: Name/Number/ Relationship:_____

RESPONSIBLE PARTY INFORMATION:

Responsible Party's Name:_____Relationship to Patient:_____
Address:_____City,State,Zip:_____
Ph#:_____Driver's License:_____DOB:_____
Employer:_____Ph#_____
Are you a patient at our office?Yes___No___ Email:_____

INSURANCE INFORMATION:

Name of Insurance:_____Ph#_____
Policy Holder's Name:_____Relationship to Patient:_____
DOB:_____SS#_____Employer:_____
Employer Ph#:_____City,State,Zip:_____

ADDITIONAL INSURANCE INFORMATION:

Name of Insurance:_____Ph#_____
Policy Holder's Name:_____Relationship to Patient:_____
DOB:_____SS#_____Employer:_____
Employer Ph#:_____City,State,Zip:_____

HIPAA AUTHORIZATION:

I acknowledge that I have received a copy of Dental Park's HIPAA Notice of Privacy Practices.
Patient Name:_____

_____ _____ _____
Signature of Patient, Parent, Legal Guardian Relationship to Patient Date

Please Note: It is your right to refuse to sign this Acknowledgement.

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Dental Office Use Only

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:
*An emergency prevented us _____ *A communication barrier ____ *Unwilling Individual ____ *Other ____
Staff Signature:_____Date:_____

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_____ _____ _____
***Signature of Patient, Parent, Legal Guardian Relationship to Patient Date

****I ATTEST THAT ALL INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR OF ANY CHANGES IN MY INFORMATION OR HEALTH.****

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DENTAL HISTORY: ******Please sign footer when completed.******

Reason for today's visit:_____Date of last dental care:_____

Former Dentist:_____Date of last dental x-rays:_____

Address:_____Ph#:_____

Check if you have had problems with any of the following:

*Sensitivity to: Hot___Cold___Sweets___ *Sensitivity when biting___ *Bleeding gums___ *Clicking or popping jaw___ *Broken fillings___ *Periodontal Treatment___ *Bad Breath___ *Loose teeth___ *Grinding teeth___ *Sores in mouth___ *Food collection between teeth___

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

Has any physician or dentist ever recommended antibiotics prior to dental treatment? ___Yes ___No

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MEDICAL HISTORY:

Physician's Name:_____Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ___Yes ___No Have you ever taken Fosamax or Actonel? ___Yes ___No

Have you had any serious illnesses or operations? ___Yes ___No - If yes, explain:_____

Have you ever had a blood transfusion? ___Yes ___No - If yes, list approximate date:_____

Women Only: *Are you pregnant?___Yes___No *Nursing ___Yes ___No *Using birth control? ___Yes ___No

Are you allergic to any of the following? (*Check yes or no)*

Y	N		Y	N	
____	____	Anesthetic	____	____	Iodine
____	____	Aspirin	____	____	Latex
____	____	Codeine	____	____	Penicillin
____	____	Ibuprofen	____	____	Sulfa
____	____	Other, If yes please explain:_____			

Do you have any of the following medical conditions? (*Check yes or no)*

Y	N		Y	N	
____	____	Asthma	____	____	Kidney Disease
____	____	Bleeding Problems	____	____	Liver Disease
____	____	Cancer	____	____	Pregnancy
____	____	Diabetes	____	____	Psychiatric Treatment
____	____	Heart Murmur	____	____	Sinus Trouble
____	____	Heart Trouble	____	____	Stroke
____	____	High Blood Pressure	____	____	Ulcers
____	____	Joint Replacement	____	____	Rheumatic Fever
____	____	Tuberculosis	____	____	Exposure to anyone with active tuberculosis
____	____	**Other**, if yes please explain:_____			

Do you use tobacco? ____Yes ____No - If yes how much?_____

Are you taking medications? ___Yes ___No - **If Yes**, please list all: _____

_____

****

_____ _____ _____

***Signature of Patient, Parent, Legal Guardian Relationship to Patient Date

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