PATIENT INFORMATION

NAME_____ D.O.B._____/_____/_____AGE_____

ADDRESS_____CITY_____STATE_____

ZIP_____ CELL PHONE #_____HOME #_____

EMAIL_____ SEX _____ M_____F SOCIAL SECURITY # _____-____-_____

MARITAL STATUS (**CIRCLE ONE**) SINGLE DIVORCED SEPARATED WIDOWED MARRIED

EMPLOYER_____ OCCUPATION_____

SPOUSE NAME _____ SPOUSE EMPLOYER_____

RESPONSIBLE PARTY OF ACCOUNT?_____ WORK PHONE# _____

HOW DID YOU HEAR ABOUT US?_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

NOTICE: X_____, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM DR. DAVID HARNETT, DR. ASHLEY SMEGAL, DR. LYDIA ELLERHORST AND DR. JARED BOWEN. (PLEASE SEE FRONT DESK IF YOU WOULD LIKE A COPY OF HIPAA PAPERS) ***PLEASE SIGN AT THE X**

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE **SELF PAY**_____

INSURED'S NAME:_____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

INSURED'S SOCIAL SECURITY # _____ - ____ - _____ INSURED'S DOB _____

INSURED'S EMPLOYER _____ MEMBER ID #_____

PRIMARY INSURANCE COMPANY _____

SECONDARY DENTAL INSURANCE

INSURED'S NAME:_____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD

INSURED'S SOCIAL SECURITY # _____ - ____ - _____ INSURED'S DOB _____

INSURED'S EMPLOYER _____ MEMBER ID #_____

PRIMARY INSURANCE COMPANY _____

ULTIMATELY, MY BILL IS MY RESPONSIBILITY! I AGREE TO ALL THE ABOVE INFORMATION AND I AGREE TO PAY MY BILL. I GIVE PERMISSION FOR MY SIGNATURE TO BE ON FILE FOR SUBMITTING TO MY INSURANCE, IF APPLICABLE. *PLEASE SIGN AT THE X

SIGNATURE:X_____ DATE:_____/____/_____

Birth Date:

Although dental personnel primarily treat the area in and around your mouth; your mouth is a part of your entire body. Heath problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now?	○ Yes	○ No	If yes _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes _____
Are you taking any medications, pills or drugs?	○ Yes	○ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or	○ Yes	○ No	if yes _____
any other medications pertaining to bisphosponates?	○ Yes	○ No	If yes _____
Are you on a special diet?	○ Yes	○ No	If yes _____
Do you use smoke, chew, or vape?	○ Yes	○ No	If yes _____
Have you been diagnosed with Sleep Apnea?	○ Yes	○ No	If yes _____
If yes, do you use a c-pap?	○ Yes	○ No	If yes _____
Do you or your family have a history of oral cancer?	○ Yes	○ No	If yes _____
Do you drink alcohol?	○ Yes	○ No	If yes _____
Do you use controlled substances?	○ Yes	○ No	If yes _____
Do you have dry mouth?	○ Yes	○ No	If yes _____

Women: Pregnant/Trying to get pregnant? ☐ Nursing? ☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ○ NONE
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic
Other?_____

Do you have, or have you had, any of the following? (PLEASE ANSWER YES OR NO)

AIDS/HIV Positive	Yes○	No○	Excessive Thirst	Yes○	No○	Low Blood Pressure	Yes○	No○
Alzheimer's Disease	Yes○	No○	Emphysema	Yes○	No○	Lung disease	Yes○	No○
Anaphylaxis	Yes○	No○	Epilepsy or Seizures	Yes○	No○	Mitral Valve Prolapse	Yes○	No○
Anemia	Yes○	No○	Excessive Bleeding	Yes○	No○	Osteoporosis	Yes○	No○
Angina	Yes○	No○	Fainting Spells/Dizziness	Yes○	No○	Pain in Jaw Joints	Yes○	No○
Arthritis/Gout	Yes○	No○	Frequent Cough	Yes○	No○	Parathyroid Disease	Yes○	No○
Artificial Heart Valve	Yes○	No○	Frequent Headaches	Yes○	No○	Psychiatric Care	Yes○	No○
Artificial Joint	Yes○	No○	Glaucoma	Yes○	No○	Radiation Treatments	Yes○	No○
Asthma	Yes○	No○	Hay Fever	Yes○	No○	Recent Weight Loss	Yes○	No○
Blood Disease	Yes○	No○	Heart Attack/Failure	Yes○	No○	Renal Dialysis	Yes○	No○
Blood Transfusion	Yes○	No○	Heart Murmur	Yes○	No○	Rheumatic Fever	Yes○	No○
Breathing Problems	Yes○	No○	Heart Pacemaker	Yes○	No○	Rheumatism	Yes○	No○
Bruise Easily	Yes○	No○	Heart Trouble Disease	Yes○	No○	Scarlet Fever	Yes○	No○
Cancer	Yes○	No○	Hemophilia	Yes○	No○	Shingles	Yes○	No○
Chemotherapy	Yes○	No○	Hepatitis A	Yes○	No○	Sickle Cell Disease	Yes○	No○
Chest Pains	Yes○	No○	Hepatitis B or C	Yes○	No○	Sinus Trouble	Yes○	No○
Cold Sores/Fever blisters	Yes○	No○	High blood Pressure	Yes○	No○	Stomach/Intestinal Disease	Yes○	No○
Congenital Heart Disorder	Yes○	No○	High Cholesterol	Yes○	No○	Stroke	Yes○	No○
Convulsions	Yes○	No○	Hives or Rash	Yes○	No○	Swelling of Limbs	Yes○	No○
Yellow Jaundice	Yes○	No○	Hypoglycemia	Yes○	No○	Thyroid disease	Yes○	No○
Cortisone Medicine	Yes○	No○	Irregular Heartbeat	Yes○	No○	Tonsillitis	Yes○	No○
Diabetes	Yes○	No○	Kidney Problems	Yes○	No○	Tuberculosis	Yes○	No○
Drug Addiction	Yes○	No○	Leukemia	Yes○	No○	Tumors or Growths	Yes○	No○
Easily Winded	Yes○	No○	Liver Disease	Yes○	No○	Ulcers	Yes○	No○

Have you ever had any serious illness not listed Yes No If yes:_____
Additional Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing in correct information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical statues. *PLEASE SIGN AT THE X

Signature:X_____ DATE_____/_____/_____