New Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions about your medical and dental health. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

Date:____________________

Patient Name:____
(Last) (First) (Middle Initial) (Name you wish to go by)

Address:____
(Address) (City / State / Zip)

Patient's Date of Birth:__________________ Home Phone:__________________

Patient's SS#:______-______-________ Cell Phone:__________________

Patient's Occupation:____________________________ Work Phone:__________________

Employer & Address:____

Martial Status: Single______ Married______ Widowed ______ Divorced ______

Spouse Name:____________________Spouse Employment:____________________

In case of Emergency, Whom should we notify?______________________________
(Name & Relationship) (Phone #)

Whom should we thank for referring you to our office?______________________________

Most convenient Appointment time:__________________ Email address:____________________
(email for patient contact purposes only)

MEDICAL HISTORY

General Health: Excellent______ Good______ Fair______ Poor______

Name of Physician:____________________________ Last date complete physical:____________

Are you under physical care other than routine visits? Yes______ No______

If yes, for what purpose?____

Are you taking any medication at this time? Yes______ No______

If yes, please list:____

HAVE YOU EVER BEEN TREATED FOR: *(please circle)*

Heart Disease	Yes	No	Heart Murmur	Yes	No
Rheumatic Fever	Yes	No	Asthma Hay Fever	Yes	No
Abnormal Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Arthritis	Yes	No	Latex allergy	Yes	No
Hepatitis	Yes	No	Active Tuberculosis or Lung Disease	Yes	No
Diabetes	Yes	No	Artificial joint replacement	Yes	No
Epilepsy	Yes	No	Sexually transmitted Diseases	Yes	No
Stroke	Yes	No	HIV / AIDS Infection	Yes	No
Thyroid Condition	Yes	No	Drug or Alcohol Therapy	Yes	No

Do you have any known allergies to Medications such as Penicillin, Codeine, Novocaine, Other?__________________

Are you subject to prolonged bleeding?________ Fainting Spells?________

Do you Smoke or use any other Tobacco product?__________ How much per day?________

WOMEN)Are you taking Birth Control Pills?__________ Are you now Pregnant?________ How far along?________

(OVER PLEASE) >>>

DENTAL HISTORY

Reason For Visit:________________________________

When was your last Dental visit and for What?________________________________

How often do you Brush your teeth?________________________________

Do you Floss Regularly?.. Yes No

Do your Gums Bleed while brushing or flossing?.. Yes No

Do you avoid brushing any part of your mouth because of pain?.. Yes No

If Yes, where?________________________________

Do you feel twinges of pain when your come in contact with:

Heat (soup, coffee, etc.)?.. Yes No

Cold (cold liquids, ice cream, etc.)?.. Yes No

Sweets (candy, fruit, desserts, etc.)?.. Yes No

Biting Pressure?.. Yes No

Do you chew on only one side of your mouth?.. Yes No

If Yes, explain?________________________________

Do your gums feel tender or swollen?.. Yes No

Do you clench or grind your jaws while sleeping or during the day?.. Yes No

Have you noticed any swelling in your mouth or on your gums around any teeth?.. Yes No

Are you concerned with keeping your natural teeth as long as possible?.. Yes No

Do you usually have many cavities?.. Yes No

Do you lose fillings or break fillings easily?.. Yes No

Are you unhappy with your smile or any particular aspect of of the way your teeth look or feel?.. Yes No

If Yes, please explain:________________________________

Are there any changes you would like to make in your smile?.. Yes No

If Yes, please explain:________________________________

Do you have any missing teeth?.. Yes No

Have they been replaced?.. Yes No

If No, please give reason:________________________________

Are you familiar with the term "Preventive Dentistry"?.. Yes No

Please add anything you feel is important for us to know:________________________________

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Patient SignatureX________________________________
(PARENT SIGNATURE IF PATIENT IS A MINOR)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Financial Policy

In order to minimize costs associated with billing and the costs of our dental services to you in advance, payment is expected at the time services are rendered unless prior financial arraignments have been made. For your convenience, we gladly accept *Cash* or *Check*, as well as *Visa*, *MasterCard*, and *Discover*. Our office also accepts CareCredit®. For more information about our payment options please ask the front office staff!

For our patients who are covered by DENTAL INSURANCE, as a courtesy, we are happy to assist in filing your insurance. We file *primary insurance only*, you will be responsible for filling any secondary coverage(s) you might have. We ask that you pay for your estimated co-payment (the amount insurance does not pay) at each appointment. Since the insurance agreement is between you and your insurance company, we do not assume responsibility if, for any reason, they deny payment for treatment. If, after 75 days your insurance company has not met their obligation on your behalf, you will be responsible for total payment. Of course, should any problems arise we will be more than happy to provide your insurance company with any additional information that is necessary.

I have read the financial policies of Dr. Dale R. Dunn's office and understand them in full. I agree to the above stated policies. I understand that Dr. Dunn offers a courtesy service by accepting assignment from my insurance company and by filing my insurance for me and/or my family. I understand that ultimately the financial responsibility for dental services provided in this office for my self and/or my family is mine. I further understand that a 1.5% finance charge may be added to past due balance after 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Please sign below that you have read and fully understand the above policy:

X______________________________________ Date:__________________
(Financially Responsible Parties Signature)

Financially Parties Relationship to Patient: ______________________________

*****IF PATIENT IS A STUDENT, PLEASE COMPLETE:***

School Attending:______________________________ Full Time or Part Time

*****IF PATIENT IS A CHILD, PLEASE GIVE COMPLETE NAMES OF BOTH PARENTS:***

Mother:____________________ Father:____________________

*****PATIENTS COVERED BY DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING:***

Patient's Name:______________________________ Date of Birth:__________________

Patient's Relationship to Insured: Self________ Spouse________ Child________ Other________

Insured's Name: ______________________________

Insured SS#: ____________________ Date of Birth:____________________

Insured's Employer:______________________________

Name of Insurance Company:______________________________

Insurance Address:______________________________

Insurance ID#: ____________________ Group Policy #:____________________

Insurance Phone #: (________)____________________

*****ASSIGNMENT OF BENEFITS FOR DENTAL INSURANCE:***

I authorize the release of any information relating to my dental treatment to the dental insurance company claims.
In addition, I hereby authorize my insurance company to pay directly to Dale R. Dunn, D.D.S., for all dental services performed.

Signed:X______________________________________ Date:__________________
(Responsible Party or Patient)