

Annapolis
DENTAL CENTRAL

CONFIDENTIAL PATIENT INFORMATION

Today's Date: ____/____/____

Patient Name: _____
Last First M.I.

Preferred Name: _____

Date of Birth: ____/____/____ **Social Security #:** _____

E-Mail: _____

Address: _____ **City:** _____

State: ____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

Patient's/Parent's Employer: _____

Occupation: _____

Gender: Male Female **Status (check one):** Minor Single Married Separated Divorced Widowed

Name of Parent/Spouse: _____ **Employer:** _____

Work Phone: _____

Person Responsible for This Account (if different than patient): _____

Relationship to Patient: _____

Date of Birth: ____/____/____ **Social Security #:** _____

Address (if different than above): _____

Phone: _____

Employer: _____

Work Phone: _____

Primary Insurance Company: _____

Insurance Phone: _____

Primary Insurance subscriber: _____ **Employer:** _____

Date of Birth: ____/____/____ **social security #:** _____

Do you have secondary Dental Insurance? Yes No **If Yes, secondary Insurance company:** _____

Is anyone in your family already a patient in this office? Yes No

How did you hear about Annapolis Dental Center? _____

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also give this office permission to release my dental records to another dental provider or myself at my verbal request.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain privacy rights regarding my protected health information and uses for such information. I have received a copy of Annapolis Dental Center Notice of Privacy Practices, read, and understand these practices. I understand that these practices may be changed at any time. I understand I may request in writing restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations. Annapolis Dental Center may not agree to such requests, but if agreed to then Annapolis Dental Center is bound by that request.

Signature of Patient (or parent if minor): _____

Date: ____/____/____

PATIENT MEDICAL AND DENTAL HISTORY

Patient Name: _____ Today's Date: ____/____/____

Emergency Contact: _____ Relationship: _____ Phone: _____

Physician: _____ Phone: _____ Last Exam Date: ____/____/____

Previous Dentist: _____ X-Rays: _____ Last Exam Date: ____/____/____

Are you currently under medical treatment? Yes No If Yes, please explain: _____

Please explain any surgery or serious illness you have had in the last 5 years: _____

Please list any medications that you are taking, including non-prescription medications, herbs, vitamins, and oral contraceptives:

| Medication | Dosage | Reason |
|------------|--------|--------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list any medications that you are allergic to, or have had a reaction to: _____

Are you allergic to Latex? Yes No Do you use tobacco? Yes No

WOMEN: Are you pregnant or think you may be pregnant? Yes No Are you nursing? Yes No

Please check any of the following conditions that you have, or have had in the past:

- High Blood Pressure
- Low Blood Pressure
- Heart Disease
- Angina
- Chest Pains
- Heart Attack
- Rheumatic Fever
- Heart Murmur*
- Mitral Valve Prolapse*
- Cardiac Pacemaker
- Stroke
- Asthma
- Emphysema
- Tuberculosis
- Easily Winded
- Frequently Tired
- Anemia
- Diabetes
- Kidney Disease
- Thyroid Problem
- HIV/AIDS
- Epilepsy/Convulsions
- Fainting/Seizures
- Cancer or Leukemia
- Radiation Therapy
- Hepatitis/Jaundice
- Liver Disease
- Stomach Ulcers
- Glaucoma
- Recent Weight loss
- Arthritis
- Joint Replacement*
- Joint Implant*
- Swollen Ankles
- Bleeding or Clotting Problems
- Artificial Stents or Shunts

If you have any of the conditions with an asterisk (), please contact our office prior to your appointment, as you may require Pre-Medication.

Reason for today's visit: _____

Please circle Yes (Y) or No (N) in response to the following:

- Y N Is fluoride taken in any form?
- Y N Bad breath?
- Y N Brush daily?
- Y N Floss daily?
- Y N Headaches, ear aches, or neck pain?
- Y N Gums bleed when you brush?
- Y N Facial pain?
- Y N Periodontal gum treatments?
- Y N Orthodontic (braces) treatment?
- Y N Clicking or popping in jaw joints?
- Y N Removable dental appliances?
- Y N Injuries to teeth or jaw? If Yes, please explain _____
- Y N For your child, any mouth habits? (thumb sucking, pacifier, nail biting, etc.)

Have you had a serious/difficult problem associated with any previous dental treatment? Yes No

If Yes, please explain: _____

How would you describe your current dental health? _____

How do you feel about your teeth's appearance? _____

Would you like to hear about ways we can improve the look of your smile? Yes No

Authorization and Release

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 if minor): _____ Date: ____/____/____