Patient Information

Date:_____

Name:_____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last *First* *M*

Address:_____
Street *Apt #* *City* *State* *Zip*

Birth Date:____/____/____ Telephone:_____
Home *Work*

Place of Employment _____

Social Security Number _____-_____-_____ Drivers License Number_____

If Full time Student, School Name:_____ Grade_____

Dental Insurance Company:_____ Group #_____

Has any member of your family been treated in our office? ☐ Yes ☐ No Local #_____

Whom may we thank for referring you to our office?_____

Family Information

Husband (Father for minor patient)

_____
Last *First* *M*

_____
Street *City* *State* *Zip*

_____
Home # *Work #*

_____
Birth Date (Mo/Day/Year) *SS#*

_____
Employer *Drivers License #*

_____
Dental Insurance Co *Group #*

Wife (Mother for minor patient)

_____
Last *First* *M*

_____
Street *City* *State* *Zip*

_____
Home # *Work #*

_____
Birth Date (Mo/Day/Year) *SS#*

_____
Employer *Drivers License #*

_____
Dental Insurance Co *Group #*

Emergency Information

Outside of Immediate Family/Household

Name _____

Address_____

City/State/ZIP_____

Telephone #_____

Responsible Party

Please check one

☐ Patient ☐ Father ☐ Husband
☐ Guardian ☐ Mother ☐ Wife

Responsible party currently has an account with this office ◯ Yes ◯ No

Payment in full at each appointment: ☐ Cash ☐ Check

Payment in full at each appointment: ☐ VISA ☐ MC

Card #_____ Exp. Date_____

I ☐ I wish to discuss the office financial policy (for cases greater then $2,000)

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am a responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

_____
Signature

☐ Adult Patient ☐ Father ☐ Husband ☐ Mother ☐ Wife ☐ Guardian

Patient Information

Medical History

Patient Name_____ **Date**_____

	Yes	No
Are your under a physician's care now? Why? Who?_____	☐	☐
Have you ever been hospitalized or had a major operation? Describe_____	☐	☐
Have you ever had a serious injury to your head or neck? Describe _____	☐	☐
Are you taking any medications, pills or drugs? What?_____	☐	☐
Are you on a special diet? Describe _____	☐	☐

Are you allergic to any medications or substances? Please check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ ☐

Describe_____

Please check yes or no to any conditions listed below

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments *(Radiation)*	☐	☐	Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐
Congenital Heart Disorder *	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS*	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A *(Infectious)*	☐	☐	Herpes (Cold Sore)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B *(Serum)*	☐	☐	Drug Addiction	☐	☐
Cold Sores	☐	☐	Fever Blisters	☐	☐	Stroke	☐	☐	Genital Herpes	☐	☐

	Yes	No
Have you ever been told by your physician that you need medication for dental treatment?	☐	☐
Have you ever had any other serious illness not checked above? Describe_____	☐	☐
Do you wish to talk to the dentist privately about any problem?_____	☐	☐

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. If you are taking any medications legal or illegal, prescription, non-prescription, it is imperative that you inform us immediately.

_____ _____

Patient's Signature *Date*

Reviewed by Doctor_____ Date_____ BP_____

History review and significant findings:_____

_____

_____

Medical History

Dental History **Patient Name**_____ **Date**_____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

	Yes	*No*
Do you have a specific dental problem? Describe _____	☐	☐
Do you have dental examinations on a routine basis? Last visit_____	☐	☐
Do you think you have active decay or gum disease?_____	☐	☐
Do you brush and floss on a routine basis? Describe_____	☐	☐
Do your gums ever bleed? Describe_____	☐	☐
Does food catch between your teeth? Any loose teeth?_____	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?_____	☐	☐
Have your past experiences in a dental office always been positive?_____	☐	☐
Do you smoke or chew? Any sores or growths in your mouth? Describe_____	☐	☐
Name of previous dentist (Optional)_____	☐	☐
Why did you leave your last dentist?_____		
Date of last full mouth x-rays (16 small films or panoramic)_____		
Have you ever had any other serious dental condition not checked above? Describe_____	☐	☐
Do you wish to talk to the dentist privately about any problem?_____	☐	☐
If you could change anything about your smile, what would you change?_____		
_____		
Do you have a denture or partial denture? ☐ No ☐ Yes How old are they?_____		
If you have a denture or partial denture, how do you like them? Describe_____	☐	☐
Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment?_____	☐	☐

_____ _____

Patient's Signature *Date*

Reviewed by Doctor_____ Date_____ BP_____

History review and significant findings: _____

_____

_____

_____

Dental History

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Sam Antoon, D.M.D., P.A.**

Telephone: **972-267-5000** Fax: **972-267-5002**

Email: **plano-dentist@prodigy.net**

Address: **6521 Preston Road, Suite 300, Plano, TX 75024**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.