Welcome to A+ Dental!

Date: ____/____/_____

Thank you for choosing our office for your dental needs!

In order to serve you better, please provide the following information. ***All information will be kept confidential.***

Patient Name: _____
(Last) (First) (Middle)
Social Security #: _____-_____-_____ Sex: M / F
Date of Birth: ____/____/____

Responsible Party Information

Parent/Guardian Name: _____
(Last) (First) (Middle)
Date of Birth: ____/____/____
Relationship to patient: _____
Marital Status: _____
Address: _____
City: _____State: _____ Zip Code: _____
Drivers License #: _____ State: _____
Phone #: (_____) _____
Cell #: (_____)_____
Work #: (_____)_____
Email Address: _____@_____
Emergency Contact #: (_____)_____
Employer: _____
Occupation: _____
# of Years Employed: _____
What is the reason for today's visit? _____
Whom can we thank for referring you to us? _____

To the best of my knowledge, all of the above responses are accurate. Should anything change I will notify the office.

(Signature) _____

In order to do a thorough exam, X-rays may be necessary. I hereby give consent for X-rays to be taken.

(Signature) _____

☐ ***Please indicate here if there is a chance the patient may be pregnant***

Length of time pregnant: _____ weeks

Patient Name: _____

Date of Birth: _____/_____/_____

Medical History

**** It is extremely important that all medical conditions be disclosed.*** *Certain medications/medical conditions may affect how dental treatment is planned, and may pose serious risks to you/your child's health if not disclosed.*

Are you or your child under the care of a doctor? Yes / No
Name and address of physician: _____
Physician's Phone #: (_____)_____
☐ If you are female, is there a chance you might be pregnant?
If yes, how long? _____ weeks

Check any of the following conditions which you/your child have or have had in the past:
* *Please disclose ALL information* *
☐ Hospital visit(s) in the past:
Reason: _____ Date(s) _____
☐ Surgeries:
Reason: _____ Date(s) _____
☐ Medication(s) **including herbal supplements*
Name(s) & Dosage: _____
☐ Allergies to any Medications, Materials, Foods:
Please list: _____
☐ Medical / Mental / Developmental Conditions or Disorders:
Please list: _____
- ☐ Heart Disease/Defects (Murmur, Heart Attack, Valve Disorders, Heart Surgeries, etc)
  - ☐ Congenital Heart Defects (VSD, Mitral Valve Prolapse, etc)
  - ☐ High Blood Pressure (Hypertension)
  - ☐ Rheumatic Fever, Rheumatic Heart Disease
  - ☐ Irregular Heart Beat(s)
- ☐ Snoring, Sleep Apnea, Mouth Breathing, Excessive Gagging
- ☐ Asthma: Frequency of Symptoms: _____
  Hospitalized for Asthma? Y / N Date(s): _____
- ☐ Cystic Fibrosis
- ☐ Other Respiratory Disorders (Bronchitis, COPD, Tuberculosis, Reactive Airway Disease, etc)
  - ☐ Frequent coughs, pneumonia, or illness
- ☐ Diabetes: ___ Type I (IDDM) or ___ Type II (Non-IDDM)
- ☐ Blood/Bleeding Disorders (Sickle Cell Disease/Trait, Anemias, Clotting Disorders, Hemophilia, etc)
  - ☐ Blood Thinning Medications / Anticoagulant Therapy (Aspirin, Warfarin, etc.)
  - ☐ Blood Transfusions or Blood Products (Amicar,
- ☐ Developmental Disorders, Learning Problems/Delays, Intellectual Disability
- ☐ ADHD/ADD
- ☐ Autism/Autism Spectrum Disorder (Asperger's, Autism, etc)
- ☐ Psychiatric or Emotional Disorders (Schizophrenia, Depression, Anxiety, etc)
- ☐ Syndromes or Developmental Conditions (Down, DiGeorge, Williams, etc)
- ☐ Seizures, Epilepsy, Seizure Disorder: *Frequency of Seizures: _____
- ☐ Cerebal Palsy, Traumatic Brain Injury, etc
- ☐ Liver Disease, Hepatitis, Jaundice
- ☐ Ulcers, GERD, Acid Reflux, Intestinal Problems
  - ☐ Chron's Disease, Celiac Sprue, Gluten Allergy
- ☐ Kidney or Bladder Disorders/Disease
- ☐ Immune Disorders/Suppression (HIV, AIDS, prolonged steroid use, etc)
- ☐ Thyroid, Pituitary Disorders
- ☐ Cancer, Tumor(s), Malignancy, Chemotherapy, Radiation Therapy, Bone Marrow Transplant, Organ Transplant

☐ Any other medical condition not listed above: _____
* Please provide descriptions to positive responses above: _____
_____

To the best of my knowledge, all medical conditions, medications, past surgeries/hospitalizations have been disclosed. I understand that full disclosure of any medical conditions is extremely important in minimizing any risk of adverse outcomes, as well as diagnosis and treatment of any oral/dental conditions. I will notify the office if there are any changes to my/my child's health history, or changes in medications at the next appointment.

(Signature) _____ Date: _____/_____/_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED & DISCLOSED, & HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please read it and review it carefully.

Summary:
Federal Law mandates that we protect the privacy of your/your child's health information, and provide you with our *Notice of Privacy Practices*. This notice describes how your/your child's medical/dental health information may be used and disclosed by us. It also describes how you can obtain access to this information.

Your health information will be used/disclosed *only* for the following:
To coordinate treatment for you or your child, based on medical and dental conditions present and past;
To coordinate treatment or consult with other healthcare providers involved in your/your child's healthcare;
To coordinate billing/payments with you or your third party payer (i.e. – Medicaid, insurance, etc)

If we need to use your protected health information for purposes other than those stated above, we will request your written consent prior to doing so.

As a patient you have the following rights:
The right to inspect a copy of your health information;
The right to make corrections to your information;
The right to request that your information be restricted;
The right to request confidential communications;
The right to a report of disclosures of your information;
The right to a paper copy of this notice

We assure you that we take our duty to protect your family's protected health information very seriously.
Further information for concerns regarding your rights may be found at:
https://www.hhs.gov/programs/hipaa/index.html
Please contact our office manager if you have any questions or concerns regarding our office's policies.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this Notice of Privacy Practices, and am entitled to a written copy if I request one. I also understand that should this Notice be updated or modified, I will be given the opportunity to review and sign it.

_____
Printed Name of Patient/Legal Guardian

_____
Signature of Patient/Legal Guardian

_____/_____/_____
Date