one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth
❑ Other: _____
Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know
Previous Dentist: _____ (____) _____
Name Phone#
Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____
Times a day you brush? _____ Times a week you floss? _____
What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** _____
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No
Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____
Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____
Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No
For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____
Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ____/____/____ Date
Comments
Initials ____/____/____ Date
Comments
Initials ____/____/____ Date
Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Communication of Protected
Health Information

Patient Name_____ **Birth Date**_____/____/_____

The Health Insurance Portability and Accountability Act (HIPAA) requires Family Tree Dental to obtain your authorization to allow verbal and E-mail communications regarding your protected health information. This authorization allows Family Tree Dental to discuss your health care with a spouse, child, friend or other family member that you designate. It also allows Family Tree Dental to leave recorded messages at your home, work, on your cell phone or E-mail related to your health/dental care and treatment, payment, appointment status, or follow-up.

List phone number(s) in order of preference for receiving appointment reminders and/or patient care calls.

Please circle type:

Home/ Cell/ Work_____ no message/message to call/ detailed message

Home/ Cell/ Work_____ no message/message to call/ detailed message

Home/ Cell/ Work_____ no message/message to call/ detailed message

This authorization allows Family Tree Dental to discuss all aspects of my protected health information with those individual(s) listed below:

Name	Relationship	Phone#

E-mail address_____

For appointment reminders and new letters. Yes No

I understand I may refuse to sign this authorization and realize this may result in a delay of treatment and /or have potential adverse health/dental consequences. This authorization has not date of expiration, however, I may change or revoke it at any time. This signature does not authorize the release of disclosure of any of my written protected dental/health information.

_____

Signature of Patient or Legal Representative

Family Tree Dental

Dr. Mark D. Watson D.D.S.

I, _____, have received a copy of the office's Notice of Privacy Practices.

_____ Date_____

Signature of Patient or Legal Representative

Authorization and Release of Information

Family Tree Dental

Dr. Mark D. Watson D.D.S.

Records Release: I hereby authorize the release of any information, including medical/dental, film images and billing information, by Family Tree Dental, to my primary doctor, insurance company, the responsible party named above, and immediate family on behalf of myself and /dependent.

Signed_____Date_____

Assignment of Benefits: I hereby authorize payment of dental benefits to Family Tree Dental, for services rendered to myself and/dependent. I am responsible for any service or treatment that is not covered by my insurance company.

Signed_____Date_____

I understand I my refuse to sign the authorization and realize this may result in a delay of treatment and /or have potential adverse health/dental consequences. This authorization has no date of expiration, however, I may change or revoke it at any time.

Singed_____Date_____