Patient name____ **Date of Birth** _________________________________

Home Address ____**City**____________________________________

State____**Zip**____

Home Phone_______________________________________ **Cell Phone**____

Preferred method for contact? Cell_____________ **Home** _____________ **Email**_____________ **Text**_____________

Email Address____

Emergency Contact name and phone #____

Physician's name_______________________________ **Phone number**____

How did you hear about Complete Dentistry? ____

I last saw my dentist (mo/yr)_______________ **I was seen for : Routine Care**_____________ **Emergency care**____________

I last saw my medical doctor (mo/yr)_______________ **I was seen for** ____

I brush my teeth _________________**per day. I floss my teeth** __________________**per day or** ________________**per week**

Insurance Information:

Employer____

Primary Dental Insurance________________________________ **Subscriber ID#**___________________________________

Subscriber Name_____________________________ **Subscriber Date of birth**_______________________________________

Social Security #_____________________________**Subscriber Social Security#**____________________________________

Group #____________________________**Insurance Phone #**____

I understand that any insurance information provided by Complete Dentistry is an estimation of coverage and not a guarantee of payment. I have been given the option to ask questions regarding this and understand that Complete Dentistry has absolutely no control over my insurance benefits as that relationship is between myself, my employer, and my insurance carrier. I understand that I am responsible for payment of balances incurred after insurance denies payment or pays less than estimated. I am aware that any change in my insurance plan will change my treatment estimates and I must notify Complete Dentistry of a policy change in advance of my appointment. In the event that I do not inform Complete Dentistry of a policy change in advance, I understand that payment in full will be due and may be refunded only once insurance has issued payment on my claims.

To the very best of my knowledge I attest to the truth in the information that I have provided.

Patient Signature____ **Date** ___________________________________

Medical Health History

Check All That Apply Below:

Condition	Yes	No
Heart Problems	☐ Yes	☐ No
Angina	☐ Yes	☐ No
I can walk up a flight of stairs?	☐ Yes	☐ No
Heart Arrhythmia:	☐ Yes	☐ No
Type:_______________Year_________		
Heart Valve Problem or Replacement:	☐ Yes	☐ No
Details:___________________________		
Rheumatic Fever	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Easy Bruising	☐ Yes	☐ No
Blood Disease (Anemia)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Back/Neck Pain	☐ Yes	☐ No
Artificial Hip:	☐ Yes	☐ No
Placement Year:_____________________		
Artificial Knee:	☐ Yes	☐ No
Placement Year:_____________________		
Diabetes:	☐ Yes	☐ No
Most Recent A1C:________________ Date:_________		
Tuberculosis	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Cancer:	☐ Yes	☐ No
Type:__________________Year:_________		
Hepatitis	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Smoking/Tobacco Use	☐ Yes	☐ No
Type:_____________________________		
Cold Sores	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
High Daily Stress	☐ Yes	☐ No
Are You Pregnant:	☐ Yes	☐ No
Due Date:__________________________		
Are You Nursing	☐ Yes	☐ No

PATIENT NAME:_________________________________

PATIENT SIGNATURE:____________________________

DATE:_______________

Dental Questions:

Question	Yes	No
Grind My Teeth at Night	☐ Yes	☐ No
Clench My Teeth During The Day	☐ Yes	☐ No
Wear A Night Guard	☐ Yes	☐ No
History of Gum Disease	☐ Yes	☐ No
Consume Soda	☐ Yes	☐ No
Consume Energy Drinks	☐ Yes	☐ No
Dental Anxiety	☐ Yes	☐ No
Tooth Pain Today	☐ Yes	☐ No
I Like My Smile	☐ Yes	☐ No
Interest in Cosmetic Dentistry	☐ Yes	☐ No
Interest in Whitening	☐ Yes	☐ No
Interest in Tooth Straightening	☐ Yes	☐ No

Have You At Any Point Taken Any of The Following Drugs:

Drug	Yes	No
Didronel (Etidronate)	☐ Yes	☐ No
Skelid (Tiludronate)	☐ Yes	☐ No
Fosamax (Alendronate)	☐ Yes	☐ No
Actonel (Riserdronate)	☐ Yes	☐ No
Boniva (Ibandronate)	☐ Yes	☐ No
Aredia (Pamidronate)	☐ Yes	☐ No
Zometa (Zoledronate)	☐ Yes	☐ No
Reclast (Zoledronic Acid)	☐ Yes	☐ No

Allergies:

What Current Allergies Do You Have:

____

____

____

____

Medications:

List all Medications With Dosages:

____

____

____

____

____

____

____

____

Patient Blood Pressure: _________/_________

Patient Pulse: _________

Dentist Initials: _______

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Complete Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Complete Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (Parents, Grandchildren)	☐ YES	☐ NO
Other:	☐ YES	☐ NO
Name of patient (please print):		
Patient signature:		
Patient's personal representative: (Please Print):		
Personal Representative's signature:		
Representative's Telephone Number: **Date:**		

CANCELATION POLICY

WE REQUIRE A 72 HOUR NOTICE FOR ANY CANCELATION OR RESCHEDULE. ANY SHORT NOTICE CANCELATION (LESS THAN 72 HOURS) OR MISSED APPOINTMENT MAY RESULT IN A DEPOSIT REQUIREMENT BEFORE ANOTHER APPOINTMENT MAY BE RESERVED.

INSURANCE POLICY

I understand that any insurance information provided by Complete Dentistry is an estimation of coverage and not a guarantee of payment. I have been given the option to ask questions regarding this and understand that Complete Dentistry has absolutely no control over my insurance benefits as that relationship is between myself, my employer, and my insurance carrier. I understand that I am responsible for payment of balances incurred after insurance denies payment or pays less than estimated. I am aware that any change in my insurance plan will change my treatment estimates and I must notify Complete Dentistry of a policy change in advance of my appointment. In the event that I do not inform Complete Dentistry of a policy change in advance, I understand that payment in full will be due and may be refunded only once insurance has issued payment on my claims.