CONFIDENTIAL PATIENT INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ SSN: _____
Street

_____ HOME PHONE: _____
City/State Zip

WORK PHONE: _____ MOBILE PHONE: _____

REFERRED BY: _____ PHONE: _____

E-mail address: _____

INSURANCE AND BILLING INFORMATION

GUARANTOR OF ACCOUNT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____
Street

WORK PHONE: _____

_____ DRIVER'S LICENSE: _____
City/State Zip

STATE: _____

MEDICAL INSURANCE:

Carrier: _____ Phone: _____

Claims Address: _____ City/State: _____ Zip: _____

Insured: _____ Date of Birth: _____ SSN: _____

Group Number: _____ Employer: _____

DENTAL INSURANCE:

Carrier: _____ Phone: _____

Claims Address: _____ City/State: _____ Zip: _____

Insured: _____ Date of Birth: _____ SSN: _____

Group Number: _____ Employer: _____

ALL CHARGES ARE THE RESPONSIBILTY OF THE PATIENT OR GUARANTOR OF THE ACCOUNT AND ARE DUE AT THE TIME OF SERVICE. Filing of insurance claims is a courtesy. Estimates made by our office are not a guarantee of payment from your insurance company.

It is important for you to be familiar with the terms, exclusions and limitations of your insurance policies. We urge you to be fully aware of the provisions of your policy as benefits can vary greatly from company to company.

I agree to be responsible for all charges for services and materials not paid by my insurance plan, unless the treating doctor has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claims and/or appeals submitted by this office on my behalf. I also authorize the payment of benefits to the provider for services rendered.

Signature: _____ Date: _____

Please complete other side

MEDICAL QUESTIONNAIRE

1. Have you been a patient in a hospital in the past two years? Yes _____ No _____
   If so, for what were you hospitalized: _____
   _____
2. Are you now, or have you been, under the care of a physician, including a psychiatrist, during the past two years? If so, for what were you treated? _____ Yes _____ No _____
   _____
3. List medicines or drugs you have taken during the past year: and for what? _____
   _____
4. Have you taken cortisone or other hormone medications? If so, please list _____ Yes _____ No _____
5. Have you had any surgical procedures in the past? Please describe _____ Yes _____ No _____
6. If surgery was performed, name of surgeon: _____
7. Have you had a reaction to any medicine such as penicillin, sulfa or aspirin? _____ Yes _____ No _____
8. Have you had any hay fever or any allergies? if so, please describe. _____ Yes _____ No _____
9. When you cut yourself or have a tooth extracted, do you bleed so much that you have to see a doctor to have it stopped? _____ Yes _____ No _____
10. Have you ever had a reaction during, or following a dental treatment or oral surgery? Please describe. _____ Yes _____ No _____
11. Check the name of any of the following which you have had:

_____Stroke	_____Asthma	_____Blood Disease
_____Heart Attack	_____Shortness of Breath	_____Anemia
_____Chest Pain angina	_____Emphysema	_____Syphilis or Venereal Disease
_____Irregular Heart Beat	_____Pneumonia	_____Diabetes
_____Replacement of Heart Valve	_____Tuberculosis	_____Seizures (Epilepsy)
_____Heart Murmur	_____Hepatitis (Yellow Jaundice)	_____Cancer
_____High Blood Pressure	_____Kidney or Bladder Trouble	_____Radiation or Chemotherapy
_____Rheumatic Fever	_____Thyroid Disease	_____Nervous Disorders
_____Ulcers	_____Arthritis	_____Alcohol Abuse
_____Congenital Heart Disease	_____A.I.D.S.	_____Drug Abuse Including Marijuana
	_____Positive HIV Reaction	

12. Do you faint easily? Yes _____ No _____
13. Do you get short of breath easily? Yes _____ No _____
14. Have you gained or lost more than 15 pounds recently? Yes _____ No _____
15. Do you smoke? How much? _____ Yes _____ No _____
16. Do you have sores or growths in your mouth? Yes _____ No _____
17. Have you ever had any serious injuries to your face or jaws? Yes _____ No _____

18. WOMEN: Are you pregnant? _____ Taking Birth Control Pills? Yes _____ No _____
    PLEASE BE ADVISED THAT WHEN TAKING MOST ANTIBIOTICS THEY WILL AFFECT BIRTH CONTROL MEDICATION BY MAKING IT INEFFECTIVE RESULTING IN PREGNANCY UNLESS OTHER PREVENTATIVE METHODS ARE TAKEN
19. Do you have any disease, condition or problem not listed above that you think we should know about? _____ Yes _____ No _____
    _____

Approximate Weight _____
Approximate Height _____
Age _____

_____
Signature Date

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: 1/1/08

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date