

WHITLEY FAMILY DENTAL

PATIENT INFORMATION FORM

A. Welcome/Insurance Information

1. Patient Information

This appointment is for: Yourself Your Child Other (Explain) _____

Patient's Full Name _____ Social Security _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Gender: Male Female Marital Status: _____

E-Mail Address _____

Employed: Full Time Part Time Retired Student

Employer: _____ Occupation _____

Employer's Address: _____ Employer's Phone: _____

Name of Previous Dentist: _____ Phone: _____

Name of Physician: _____ Phone: _____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you? _____

2. Responsible Party: Who is responsible for this patient?

Relation to patient: Self Spouse Child Other (explain) _____

If Self, please move to Section 3

Name: _____ Social Security No. _____

Address: _____ City: _____ State _____ Zip Code: _____

Date of Birth: ____/____/____ Gender: Male Female

Employer: _____ Occupation: _____

Employer's Address: _____ Phone: _____

3. Dental Insurance Information

Dental Coverage: Yes No

Name of Insured: _____ Date of Birth: _____

Insured's Social Security No. _____ or Insured's ID No. _____

Employer: _____ Phone No. _____

Name of Insurance Co. _____ Phone: _____

Address of Insurance Co. _____ City: _____ State _____ Zip _____

B. Medical History

Physician's Name: _____ Physician's Phone: _____

Date of Last Visit: _____ Have you had any serious illnesses or operations? ___ Yes ___ No

Are you currently under physician's care? ___ Yes ___ No If yes, describe _____

Have you been hospitalized or had a major operation during the past two years? ___ Yes ___ No If Yes, explain _____

Have you had a serious head or neck injury? ___ Yes ___ No Are you on a Special Diet? ___ Yes ___ No

Do you use controlled substances? ___ Yes ___ No Do you use tobacco? ___ Yes ___ No if yes, how much per day? ___

Do you have any health problems that need further clarification? ___ Yes ___ No

If yes, please explain _____

Current health status: ___ Excellent ___ Good ___ Fair ___ Poor

Are you allergic to any medications? If yes, please list _____

Are you taking any medications including non-prescription medicine? If so, please list: _____

Women: Are you pregnant? ___ Yes ___ No Nursing? ___ Yes ___ No Trying to get pregnant? ___ Yes ___ No

On birth control pills? ___ Yes ___ No

Are you allergic to any of the following? ___ Aspirin ___ Penicillin ___ Local Anesthetics ___ Acrylic ___ Metal ___ Latex
___ Other _____

Check if you have had any of the following conditions:

___ AIDS/HIV Positive
___ Alzheimer's Disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Breathing Problems
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Congenital Heart Disorder
___ Convulsions
___ Cortisone Medication
___ Diabetes
___ Drug Addiction
___ Easily Winded
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting Spells/
___ Dizziness

___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Genital Herpes
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
___ Heart Murmur
___ Heart Pacemaker
___ Heart Trouble/Disease
___ Hemophilia
___ Hepatitis A
___ Hepatitis B or C
___ Herpes
___ High Blood Pressure
___ Hives or Rash
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Pain in Jaw Joints
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatments
___ Recent Weight Loss

___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Spina Bifida
___ Stomach/Intestinal Disease
___ Stroke
___ Swelling of Limbs
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Venereal Disease
___ Yellow Jaundice
___ _____
___ _____

Have you had any other serious illness not listed above? ___ Yes ___ No If Yes, explain _____

C. Dental History

Reason for this visit: _____ Are you in discomfort today? ___ Yes ___ No
Do your gums bleed when brushing? ___ Yes ___ No When flossing? ___ Yes ___ No
Have you experienced pain in your jaw? ___ Yes ___ No Do you grind your teeth? ___ Yes ___ No
Have you ever been treated for RMJ symptoms? ___ Yes ___ No If yes, explain _____
How would you describe the condition of your teeth and gums? ___ Good ___ Fair ___ Poor
How often do you brush? _____ How often do you floss? _____
How do you feel about the appearance of your smile and your teeth? _____
If you could easily and safely whiten your teeth, would you be interested? ___ Yes ___ No
Have you ever experienced any complications from medical or dental treatments? ___ Yes ___ No
Other information about your dental health or previous treatment: _____

D. Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide to sign this form. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting our office or visiting our website at www.billwhitleydds.com.

E. Financial Agreement

You have the right to read our Financial Agreement before you decide to sign this form. You may obtain a copy of our Financial Agreement, including any revisions or our agreement, by contacting our office or visiting our website at www.billwhitleydds.com.

F. Consent for Use and Disclosure of Health Information

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

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

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

Relationship to Patient: _____

Print Name _____

Signature _____ Date _____