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

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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 TMJ 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_____