PATIENT INFORMATION

NAME _____ AGE _____ SEX _____ HOME PHONE ( ) _____
FIRST MI LAST

ADDRESS _____ APT. NO. _____ WORK PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

BIRTHDATE _____ SSN _____ - _____ - _____ OCCUPATION _____
MONTH DAY YEAR

IN CASE OF EMERGENCY, CONTACT: _____ RELATIONSHIP _____ PHONE ( ) _____

ARE ANY OF YOUR FAMILY MEMBERS PATIENTS OF THIS PRACTICE? ❑ YES ❑ NO NAME _____ RELATIONSHIP _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME _____ AGE _____ SEX _____ HOME PHONE ( ) _____
FIRST MI LAST

ADDRESS _____ APT. NO. _____ WORK PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

BIRTHDATE _____ SSN _____ - _____ - _____ OCCUPATION _____
MONTH DAY YEAR

PRIMARY DENTAL INSURANCE (Leave blank only if no dental benefits)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

SECONDARY DENTAL INSURANCE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

DENTAL HISTORY

WHAT IS THE REASON FOR THIS APPOINTMENT? _____

ARE THERE ANY SPECIFIC DENTAL PROBLEMS WE SHOULD BE AWARE OF? _____

DO YOU THINK YOU HAVE ANY DECAY OR CAVITIES? ❑ YES ❑ NO HOW OFTEN DO YOU BRUSH? _____

DO YOUR GUMS BLEED EASILY WHEN BRUSHING OR FLOSSING? ❑ YES ❑ NO HOW OFTEN DO YOU FLOSS? _____

DO YOU SUFFER FROM CHRONIC BAD BREATH OR BAD TASTE? ❑ YES ❑ NO

DO YOU HAVE ANY JAW JOINT CRACKING OR PAIN? ❑ YES ❑ NO

WHAT WAS THE PURPOSE OF YOUR LAST DENTAL APPOINTMENT? _____ WHEN WAS THAT? _____

WHEN WAS THE LAST TIME YOU HAD A DENTAL CLEANING? _____ NAME OF PREVIOUS DENTIST? _____

WHEN WERE THE LAST FULL MOUTH X-RAYS TAKEN OF YOUR TEETH? _____

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH? ❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

PATIENT TREATMENT CONSENT:

- I authorize the Dentist or designated staff when appropriate to provide my (or my dependents) treatment, and provide therapeutic procedures to include administering medications as prescribed by the Dentist, and mutually agreed upon by me.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I will be charged for any and all expenses associated with the collection of my account. Furthermore, I understand that this Practice is not employed by my insurance company, and claims will be submitted on my behalf as a courtesy only. I understand I will be charged an administrative fee for re-submission of problem claims and appeals to my dental insurance.
- I assign all insurance benefits to which I am entitled to the Dentist. I authorize this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.

PREFERRED METHOD OF PAYMENT

❑ **Payment in full by cash / check**

❑ **Payment in full by VISA / MC**

❑ **Copayment in full**

Patient / Parent or Guardian Signature: _____ **Date:** _____

WE REGRETFULLY CHARGE FOR MISSED APPOINTMENTS.

MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES	NO
ANY HEART PROBLEMS	❑	❑
HEART ATTACK	❑	❑
ANGINA	❑	❑
BYPASS	❑	❑
PACEMAKER	❑	❑
STROKE	❑	❑
HIGH BLOOD PRESSURE	❑	❑
LOW BLOOD PRESSURE	❑	❑
HEART MURMUR*	❑	❑
MITRAL VALVE PROLAPSE*	❑	❑
HEART VALVE DEFECT*	❑	❑
HEART VALVE REPLACEMENT*	❑	❑
RHEUMATIC FEVER*	❑	❑
ARTIFICAL JOINT (HIP / KNEE)*	❑	❑
ANY BLEEDING DISORDERS	❑	❑
ANEMIA	❑	❑
HEMOPHILIA	❑	❑
SICKLE CELL TRAIT	❑	❑
BLOOD TRANSFUSIONS	❑	❑

	YES	NO
DO YOU SMOKE	❑	❑
LUNG/BREATHING PROLEMS	❑	❑
ASTHMA	❑	❑
BRONCHITIS	❑	❑
EMPHYSEMA	❑	❑
TUBERCULOSIS	❑	❑
SINUS TROUBLE	❑	❑
DIABETES	❑	❑
DIFFICULTY IN HEALING	❑	❑
LIVER PROBLEMS/DYSFUNCTION	❑	❑
HEPATITIS/JAUNDICE	❑	❑
KIDNEY PROBLEMS/DYSFUNCTION	❑	❑
STOMACH TROUBLE/ULCERS	❑	❑
ALCOHOLISM	❑	❑
DRUG ABUSE	❑	❑
NERVOUS OR MENTAL DISORDER	❑	❑
EPILEPSY OR SEIZURES	❑	❑
THYROID PROBLEMS	❑	❑
ADRENAL/PITUITARY PROBLEMS	❑	❑

	YES	NO
ALLERGIC REACTION TO (HIVES / SWELLING)	❑	❑
PENICILLIN	❑	❑
ERYTHROMYCIN	❑	❑
SULFA	❑	❑
CODEINE	❑	❑
ASPIRIN	❑	❑
LOCAL ANESTHETIC (NOVOCAIN)	❑	❑
ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS OR SUBSTANCES? Please list below:	❑	❑
_____		
_____		
_____		
SEXUALLY TRANSMITTED DISEASES	❑	❑
OTHER INFECTIOUS DISEASES	❑	❑
HIV / AIDS	❑	❑
CANCER / TUMOR	❑	❑
OTHER GROWTHS	❑	❑
CHEMOTHERAPY / RADIATION THERAPY	❑	❑
ARE YOU PREGNANT?	❑	❑

*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? ❑ YES ❑ NO ❑ DON'T KNOW NAME OF ANTIBIOTIC:_____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE? ❑ YES ❑ NO WHAT?_____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ❑ YES ❑ NO WHY?_____

PHYSICIAN'S NAME, ADDRESS AND PHONE:_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, PILLS, OR TONIC? ❑ YES ❑ NO LIST _____ FOR_____

(I.E. BLOOD PRESSURE, BIRTH CONTROL, STERIODS, HORMONES)

_____ FOR_____

_____ FOR_____

_____ FOR_____

_____ FOR_____

_____ FOR_____

IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED? ❑ YES ❑ NO EXPLAIN _____

NOTICE OF PRIVACY PRACTICES: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including services delivered electronically, After April 14, 2003.

Acknowledgement:

I have been offered the Notice of Privacy Practices from Dr. Nurin. I also understand that the Notice is available if I wish to take it with me. I acknowledge seeing the Notice displayed in the office of Lawrence A. Nurin, DDS in a clear and prominent location. If the notice is revised, the revised Notice available upon request on or after the effective date.

Receipt of the Notice:

_____ /

Name of Patient / Date