Patient Information (CONFIDENTIAL)

How did you hear about us? ______________________

Neighborhood Dental can now confirm appointments by email or text. Please check your preference:

❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you interested in our in-house payment program through Care Credit or Cherry Finance?

❑ Yes ❑ No

❑ Check this box if you agree to receive commercial electronic messages from Neighborhood Dental. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

Name ______________________ Birthdate __________ Home Phone __________ ❑ M ❑ F

Address ______________________ City __________ State ______ Zip ______

Email ______________________ SS#__________ Cell Phone __________

If Full Time Student, Name of School/College ______________ City __________ State ______

Patient or Parent/Guardian's Employer ______________________ Work Phone __________

Business Address ______________________ City __________ State ______ Zip ______

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone __________

Emergency Contact ______________________ Phone __________

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account ______________ Relationship to Patient __________

Address ______________________ Home Phone __________

Birthdate __________Email ______________________ Cell Phone __________

Employer ______________________ Work Phone __________ SS#__________

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam __________

1. Have you ever been diagnosed with periodontal disease?______________________
2. Have you ever been told that you snore? ______________________
3. Do you like your smile? __________ How would you rate your smile on a scale from 1-10? __________
4. What changes would you make to improve your smile?______________________

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured ______________________

Relationship to Patient ______________________

Birthdate ______________________

SS#/ID# ______________________

Name of Employer ______________________

Insurance Company ______________________

Group # ______________________

Policy ID # ______________________

SECONDARY INSURANCE

Name of Insured ______________________

Relationship to Patient ______________________

Birthdate ______________________

SS#/ID# ______________________

Name of Employer ______________________

Insurance Company ______________________

Group # ______________________

Policy ID # ______________________

Over Please...

Patient Medical History

Printed Patient Name:____________________

Do we need to update your contact information?________

Primary Care Physician: ____________________ Last Exam Date: __________

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑

If yes, please explain:____________________

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking?____________________

	Yes	No
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	❑	❑

If yes, what is the reason?

Artificial Heart Valve ❑ Congenital Heart Defect ❑
Infective Endocarditis ❑ Organ Transplant ❑

OTHER:____________________

5. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
Sulfa Drugs	❑	❑
Codeine / Narcotics	❑	❑
Acrylics	❑	❑
Food Allergies	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑

OTHER (Please list): ____________________

6. **SLEEP**

	Yes	No
a) Have you been told/know you snore?	❑	❑
b) Do you have troubles sleeping?	❑	❑
c) Do you clench or grind your teeth?	❑	❑
d) Do you have sleep apnea?	❑	❑

	Yes	No
7. Do you use tobacco / e-cigarettes?	❑	❑
8. Do you use controlled substances?	❑	❑
9. **Are you taking any blood thinners?**	❑	❑

If Coumadin (Warfarin), most recent INR:____________

	Yes	No
10. **Are you taking any bone strengthening medications (bisphosphonates)?**	❑	❑
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑
12. Do you have any special needs/requirements that we should be aware of in order to accommodate you better? *(i.e. ASD- Autism Spectrum Disorder/SPD- Sensory Processing Disorder, high anxiety, etc.)*	❑	❑

____

13. Do you have or have you had any of the following?

	Yes	No
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer **Type:**______	❑	❑
Cardiac Pacemaker / Defibrillator	❑	❑
Cognitive Impairment	❑	❑
Diabetes **Type:**______ **Most Recent A1C:**______	❑	❑
Emphysema/COPD	❑	❑
Epilepsy	❑	❑
GERD / Acid Reflux	❑	❑
Heart Attack **Date:**______	❑	❑
Heart Disease **Type:**______	❑	❑
Herpes/ Cold Sores	❑	❑
Hepatitis	❑	❑
High Blood Pressure	❑	❑
Joint Replacement	❑	❑
Kidney Disease	❑	❑
Leukemia	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Seizures	❑	❑
Stroke **Date:**______	❑	❑
Thyroid Problem	❑	❑
Tuberculosis	❑	❑

OTHER____________________

14. **WOMEN ONLY:**

	Yes	No
a) Are you pregnant or think you may be pregnant? **If yes, due date:**______	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

15. **SIGNATURE REQUIRED:**

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: ____________________

Date: __________

Over Please...

Acknowledgement of *Notice of Privacy Practices*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have read and may request a copy of Neighborhood Dental's *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that Neighborhood Dental restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand Neighborhood Dental is not required to agree to my requested restrictions, but if in agreement, Neighborhood Dental is bound to abide by such restrictions.

Signature:____ **Date:**______________

I give my permission to discuss my dental treatment (including, but not limited to: Treatment, Scheduling, Billing, Insurance) with the following groups or individuals:____

____

Signature:____ **Date:**______________