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PATIENT NUMBER

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone# _____

E-Mail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐ Purpose
of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor officially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information of the page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____

DATE _____



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PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

COMMENTS

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
Address _____
Tel. _____
2. Are you under a physician's care? YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? YES NO
(If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products). . YES NO
6. Are you allergic to any medications or substances? (please list). YES NO
7. Do you have any other allergies or hives? YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
or other medications? YES NO
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect you may be? YES NO
11. Do you use any birth control medications? YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or
been diagnosed with mitral valve prolapse? YES NO
14. Have you ever had rheumatic fever? YES NO
15. Are you aware of any heart murmurs? YES NO
16. Do you have high or low blood pressure? (please circle) YES NO
17. Have you ever had a serious illness or major surgery? YES NO
If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor,
growth or other condition? YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
21. Do you have any artificial joints/prosthesis? YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? YES NO
23. Have you ever bled excessively after being cut or injured? YES NO
24. Do you have any stomach problems? YES NO
25. Do you have any kidney problems? YES NO
26. Do you have any liver problems? YES NO
27. Are you diabetic? YES NO
28. Do you have fainting or dizzy spells? YES NO
29. Do you have asthma? YES NO
30. Do you have epilepsy or seizure disorders? YES NO
31. Do you or have you had venereal or any sexually transmitted disease? YES NO
32. Have you tested HIV positive? YES NO
33. Do you have AIDS? YES NO
34. Have you had or do you test positive for hepatitis? YES NO
35. Do you have asthma? YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? YES NO
38. Do you habitually use controlled substances? YES NO
39. Have you had psychiatric treatment? YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form?

43. Would you like to speak to the Doctor privately about any problems? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT.

MEDICAL HISTORY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Sam Dauahera, D.D.S.
www.edgebrookdentalassociates.com

Office Hours
By Appointment

Chicago, IL, 60646

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

Conduct, plant and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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