

Patient Information (CONFIDENTIAL)



WISEMAN FAMILY DENTISTRY, P.C.

How did you hear about us? _____

Wiseman Dentistry can now confirm appointments by Email or Text.

Please check your preference:

Email Text Home Phone Cell Phone

Name _____ Preferred Name _____ Birthdate _____ Home Phone _____ M F

Address _____ City _____ State _____ Zip _____

Email _____ SS# _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

If Full Time Student, Name of School/College _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ 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# _____

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 # _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease? _____

2. How would you rate your smile on a scale from 1-10? _____

3. What changes would you make to improve your smile? _____

Over Please...

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
 If yes, please explain: _____

 _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
 If yes, what medication(s) are you taking? _____

 _____</p> <p>4. Are you allergic to or have you had any reactions to the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;">Local Anesthetics (e.g. Novocaine)</td> <td style="width: 5%;"><input type="checkbox"/></td> <td style="width: 15%;"><input type="checkbox"/></td> </tr> <tr> <td>Penicillin or any other Antibiotics (Please list).....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>Sulfa Drugs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Barbiturates</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sedatives</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Iodine.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Aspirin.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Any Metals (e.g Nickel, Mercury, etc.).....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Latex Rubber.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other (Please list).....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>_____</td> <td></td> <td></td> </tr> </table> | Local Anesthetics (e.g. Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics (Please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g Nickel, Mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> | Other (Please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | _____ | | | _____ | | | <p>5. Have you ever taken Fen-Phen/Redux?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use tobacco?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use controlled substances?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you taking any blood thinners?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Are you taking any bisphosphonates?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have Hepatitis or Jaundice?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> <th style="width: 30%;"></th> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> </tr> </thead> <tbody> <tr> <td>High Blood Pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Emphysema.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart Attack</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Rheumatic Fever</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Arthritis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Fainting/Seizures.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Stroke</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Asthma</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tuberculosis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Low Blood Pressure.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Radiation Therapy....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Epilepsy/Convulsions ..</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Liver Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Leukemia.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Trouble</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Diabetes.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Respiratory Problems</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Kidney Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mitral Valve Prolapse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>AIDS or HIV Infection</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Joint Repl or Implant</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Thyroid Problem</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other (please list).....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>Cardiac Pacemaker.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>Heart Murmur</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td></td> <td></td> </tr> <tr> <td>Anemia.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> <td></td> <td></td> </tr> </tbody> </table> <p>13. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | Yes | No | | Yes | No | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy.... | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions .. | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Joint Repl or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
|---|--|--------------------------|--------------------------|--|--------------------------|--------------------------|-------|--|--|------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|--|--|-------|--|--|-------|--|--|---|--|------------|-----------|--|------------|-----------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-------|--|--|------------------------|--------------------------|--------------------------|-------|--|--|--------------------|--------------------------|--------------------------|-------|--|--|-------------|--------------------------|--------------------------|-------|--|--|
| Local Anesthetics (e.g. Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penicillin or any other Antibiotics (Please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any Metals (e.g Nickel, Mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other (Please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes | No | | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fainting/Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy.... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Epilepsy/Convulsions .. | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Joint Repl or Implant | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

HIPAA Privacy Practices, Authorization and Release

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian of Minor) _____ Date _____