

PATIENT INFORMATION

NAME FIRST MI LAST AGE SEX HOME PHONE ()
ADDRESS APT. NO. WORK PHONE ()
CITY STATE ZIP EMPLOYER
BIRTHDATE MONTH DAY YEAR SSN - - OCCUPATION

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 FIRST MI LAST AGE SEX HOME PHONE ()
ADDRESS APT. NO. WORK PHONE ()
CITY STATE ZIP EMPLOYER
BIRTHDATE MONTH DAY YEAR SSN - - OCCUPATION

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:

ANY HEART PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DO YOU SMOKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ALLERGIC REACTION TO (HIVES / SWELLING)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	LUNG/BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>
ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	ERYTHROMYCIN	<input type="checkbox"/>	<input type="checkbox"/>
BYPASS	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	SULFA	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETIC (NOVOCAIN)	<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS OR SUBSTANCES? Please list below:	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR*	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY IN HEALING	<input type="checkbox"/>	<input type="checkbox"/>	_____		
MITRAL VALVE PROLAPSE*	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS/DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	_____		
HEART VALVE DEFECT*	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS/JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	_____		
HEART VALVE REPLACEMENT*	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS/DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>			
RHEUMATIC FEVER*	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH TROUBLE/ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL JOINT (HIP / KNEE)*	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	OTHER INFECTIOUS DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
ANY BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS OR MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER / TUMOR	<input type="checkbox"/>	<input type="checkbox"/>
HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	OTHER GROWTHS	<input type="checkbox"/>	<input type="checkbox"/>
SICKLE CELL TRAIT	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY / RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	ADRENAL/PITUITARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>

*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