About You

Today's Date____/____/____

Name_____

Preferred Name_____ □M □F

Address_____

City_____State_____Zip_____

Home#_____Work#_____

Cell#_____Other#_____

□ Single □ Married □ Divorced □ Widowed

Birthdate____/____/____ Age_____

SS#_____

Email_____

Employer_____

Address_____

City_____State_____Zip_____

Occupation_____

Whom may we thank for referring you to our practice?_____

Other family members seen by us_____

_____

Insurance Information

Primary Insurance Company:

_____

Address_____

City_____State_____Zip_____

Group#_____

Insured's Name_____

Relationship to Insured_____

Insured's Birthdate____/____/_____

Insured's ID#_____

Insured's Employer_____

Secondary Insurance Company:

_____

Address_____

City_____State_____Zip_____

Group#_____

Insured's Name_____

Relationship to Insured_____

Insured's Birthdate____/____/_____

Insured's ID#_____

Insured's Employer_____

Spouse Information

Name_____

Home#_____Work#_____

Cell#_____ Birthdate___/___/_____

Email_____

SS#_____

Employer_____

Medical Information

Do you have a primary care physician? □Y□N

Physician's Name_____

Phone#_____

Date of Last Visit_____/_____/_____

Are you currently under the care of a physician? □Y □ N

Please Explain_____

Medical History

Do you smoke or use tobacco in any form?

□Y □N How long if yes_____

Are you taking any prescription, over the counter, or supplements? □Y □N

IF YES, please list on the last page.

Have you ever or do you have any of the following diseases or medical problems?

□Y □N Abnormal Bleeding

□Y □N Alcohol/Drug Abuse

□Y □N Asthma

□Y □N Cancer/Chemotherapy

□Y □N Diabetes

□Y □N Heart Attack When if Yes_____

□Y □N Herpes

□Y □N High Blood Pressure

□Y □N HIV/AIDS

□Y □N Pacemaker

□Y □N Psychiatric Problems

□Y □N Are you taking Bisphosphonates?

Oral or IV How long if yes_____

□Y □N Stroke

□Y □N Tuberculosis

□Y □N High Cholesterol

□Y □N Hepatitis

Any other medical conditions that we should be aware of?_____

_____

_____

For women only

Are you taking Birth Control Pills? □Y □N

Are you, could you be, or are you trying to become pregnant? □Y □N

Are you breastfeeding? □Y □N

Please Check Any That Apply As These May Require Premedication:

□Y □N Artificial Joints When replaced_____

□Y □N Artificial Heart Valves

□Y □N Past incidence of Infective Endocarditis

□Y □N Serious Congenital Heart Defect

□Y □N Heart Transplant

Are You Allergic to Any of the Following?

□Y □N Aspirin □Y □N Latex

□Y □N Codeine □Y □N Penicillin

□Y □N Tetracycline □Y □N Erythromycin

□Y □N Jewelry/Metals □Y □N Anesthetics

Other Allergies_____

Dental History

What brings you into our office today?

_____

Are you having any of the following?

□Y □N Tooth pain or sensitivity?

□Y □N Headaches, Earaches, Neck Pain?

□Y □N Broken teeth or fillings?

□Y □N Bleeding, swollen, or irritated gums?

□Y □N Bad taste or Bad odor in your mouth?

□Y □N Clenching or grinding of your teeth?

If you could change your smile, would you:

□ Make your teeth whiter?

□ Make your teeth straighter?

□ Close spaces between your teeth

□ Replace silver fillings with tooth colored fillings?

□ Repair chipped teeth?

□ Replace missing teeth?

□Replace old crowns that don't match?

When was your last dental appointment?

Approximate Date_____

Reason_____

Date of last x-rays_____

What is the most important thing to you about your smile and dental health?

_____

_____

Christopher D. Masoner D.D.S.

Acknowledgement of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I,_____, understand that this office abides by the HIPPA law and will protect the privacy of my personal information. I have been given a copy of the Notice of Privacy Practices form.

Please Print Name_____

Signature_____

Date_____

For Office Use Only

We attempted to obtain written acknowledgment for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited us

□ An emergency situation prevented us

□ Other_____

Please Initial on the Appropriate Lines:

___ I have read and answered the questions to the best of my knowledge.

____ I authorize the dentist to release all information necessary to secure the payment of benefits and use this signature on all insurance submissions.

____ I have read and agree to this office's financial policy and understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature:_____

Date:_____

Medical History Updates

Date	Changes	Pt Initials
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

Medication and Reason	Dosage	Date