Thank You For Choosing Legacy Smiles!

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

State ID/Driver's License #:_____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S./HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay Fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head Injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting Spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or Growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint Replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

Are you allergic to any medications? ❑ YES ❑ NO
If yes, please list below:

_____

_____

Are you in good health? ❑ YES ❑ NO

Date of last medical exam: _____

Have you ever been hospitalized? ❑ YES ❑ NO
If yes, what was the reason

_____

_____

Do you have any disease/problem you think we should know about? ❑ YES ❑ NO

_____

_____

Have you had a transplant operation that has depressed your immune system? ❑ YES ❑ NO

Do you smoke or chew tobacco? ❑ YES ❑ NO

Have you had heart surgery? ❑ YES ❑ NO

Are you now under the care of an MD? ❑ YES ❑ NO

Are you taking or have you ever taken bisphosphonates?
(Fosamax or Actonel for osteoporosis, chemotherapy, etc.) ❑ YES ❑ NO

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ YES ❑ NO

Are you pregnant? ❑ YES ❑ NO

Expected delivery date: _____

Are you nursing/breastfeeding? ❑ YES ❑ NO

Is there a possibility of pregnancy? ❑ YES ❑ NO

Dental History Information

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ YES ❑ NO

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑ YES ❑ NO

Have you or a family member ever been treated for periodontal disease? ❑ YES ❑ NO

Have you ever had complications from an extraction? ❑ YES ❑ NO

Have you ever had a popping or clicking near your ear when you chew? ❑ YES ❑ NO

Are you prone to frequent headaches? ❑ YES ❑ NO

Do you grind or clench your teeth? ❑ YES ❑ NO

Do you have sores, blisters, or swelling on your gums, lips or cheeks? ❑ YES ❑ NO

Have you ever had orthodontic treatment? ❑ YES ❑ NO

Do you snore? ❑ YES ❑ NO

Do you have problems with bad breath? ❑ YES ❑ NO

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? ❑ YES ❑ NO

Have you ever used an electric toothbrush? ❑ YES ❑ NO

Are your teeth sensitive to hot, cold or pressure? ❑ YES ❑ NO

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❑ Whiter
- ❑ Straighter
- ❑ Close space
- ❑ Replace old mercury fillings with tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Less gums showing
- ❑ Replace old crowns that don't match
- ❑ Other _____

I certify that I have read and understand the medical and history questions. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of these forms.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives or x-rays, as may be deemed necessary by the doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

PAYMENT ARRANGEMENT

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I understand that the Practice may charge: 1) a late fee if payment on my account ages past 60 days; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check. I authorize insurance payment directly to the Practice.

NAME OF PATIENT: _____ Signature: _____ Date: _____

If Patient Is A Minor Print Responsible Party Name: _____

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Employer Name: _____State ID/Drivers License # _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____ DOB: _____

Employer Name: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____ DOB: _____

Employer Name: _____

Privacy Practices Receipt/Consent From

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Patient Name: _____ **Privacy Officer: Ben C. Edmunds, DDS**

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected heath information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on the Consent before we received your revocation.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.