Tensas Dental Clinic
Quality Healthcare for Everyone.

NEW PATIENT PAPERWORK

PATIENT INFORMATION			**Today's date:**
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First*	*MI*	*Last*	
Mailing Address:	*City*	*State*	*ZIP*
Physical Address:	*City*	*State*	*ZIP*
SS#:	Birthdate:		
Home #:	Work #:	Cell#:	
Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell Occupation:			
Email Address:	Driver's License #:		
Primary Care Physician *(Shown on Insurance Card):*			

Birth Sex ☐Male ☐Female

Sexual Orientation

☐ Straight *(not lesbian or gay)* ☐ Lesbian or Gay
☐ Bisexual ☐ Other ☐ Don't know
☐ Prefer not to disclose

Gender Identity

☐ Male ☐ Female
☐ Transgender Male *(female to male)*
☐ Transgender Female *(male to female)*
☐ Genderqueer *(neither exclusively male or female)*
☐ Other ☐ Don't know ☐ Prefer not to disclose

Marital Status ☐ Single ☐ Married ☐Divorced ☐Widowed ☐Separated

Race*(check one)* ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Caucasian ☐ Black/African American
☐ American Indian/Alaska Native ☐ More than one race ☐ Prefer not to disclose

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Are you a Veteran ☐No ☐Yes

Housing Status ☐ Rent/Own ☐ Transitional ☐ Homeless ☐ Street ☐ Doubling Up ☐ N/A

Agricultural Status ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependent of Migrant
☐ Dependent of Seasonal ☐N/A

Annual Household Income ☐Less than $10,000 ☐$10,001-$20,000 ☐$20,001-$40,000
☐$40,001-$60,000 ☐$60,001-$100,000 ☐$100,000+ ☐Prefer not to disclose

Number of people living in your household: _____

RESPONSIBLE PARTY

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First* *MI* *Last*

Home #: Work #: Cell#:

Billing Address:

SS#: Birthdate: ☐ Male ☐ Female Relation:

EMERGENCY CONTACT *(Neighbor or Relative not living with you)*

His/Her Name: Relation:

Home #: Work #: Cell#:

INSURANCE INFORMATION *(Please check the type of dental insurance:)*

☐ **Medicaid Dental #:**

☐ **Medicare #:**

☐ **No Insurance**

☐ **Private/Other Insurance Name**_____

Employer/ Address:_____Phone #:_____

Policy #:_____ Group #:_____Effective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

GENERAL INFORMATION

Pharmacy Name: Phone:

Do you have reliable transportation? ☐ No ☐ Yes Do you have prescription drug coverage? ☐ No ☐ Yes

Do you currently qualify for any government programs? (*such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment)* ☐ No ☐ Yes , Please list:

If you do not currently have Medicaid, have you ever applied for Medicaid? ☐ No ☐ Yes

What was the outcome?

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MEDICAL & DENTAL HISTORY

PATIENT NAME:_____ TODAY'S DATE:_____

Reason for today's visit:_____

Are you allergic to any medications? **YES** **NO** If yes, please list:_____

Have you ever had dental anesthesia (Novocain) or local anesthesia (lidocaine)? **YES** **NO**

Any bad reactions? **YES** **NO** Explain, if yes:_____

List all medications you are currently takings ***(including prescriptions, OTC meds, vitamins, herbals)***

_____

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASE OR CONDITIONS:

LUNGS	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐

CARDIOVASCULAR	**YES**	**NO**
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Bleeding Disorder	☐	☐
Prolonged Bleeding	☐	☐

OTHER SYSTEMIC	**YES**	**NO**
Diabetes	☐	☐
Lupus	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Bladder Infection s	☐	☐
Stomach Disorder	☐	☐
Arthritics/Joint Deformity	☐	☐
Epilepsy/ Convulsions	☐	☐
Fainting/Seizures	☐	☐
Anxiety/Depression	☐	☐
Mental Disorder	☐	☐
Glasses or Contacts	☐	☐
Anemia	☐	☐
Stroke	☐	☐
Liver Disease	☐	☐
Cancer	☐	☐
Type:_____		

SOCIAL HISTORY	**YES**	**NO**
Do you Smoke?	☐	☐
Do you drink alcohol?	☐	☐
If yes, _____ per day		
Do you use IV drugs?	☐	☐
If yes, what?_____		
How often?_____		

INFECTIOUS DISEASES	**YES**	**NO**
HIV/AIDS	☐	☐
Hepatitis A, B, or C	☐	☐
Syphilis/other sexually transmitted diseases	☐	☐

FEMALES	**YES**	**NO**
Are you pregnant?	☐	☐
Could you be pregnant?	☐	☐
Date of last menstrual Cycle _____		
Type of birth control _____		

PATIENT DENTAL HISTORY	**YES**	**NO**
Bleeding gums while brushing or flossing	☐	☐
Teeth sensitivity to hot or cold liquids/foods	☐	☐
Teeth sensitivity to sweet or sour liquids/foods	☐	☐
Pain in any of your teeth?	☐	☐
Any sore or lumps in or near your mouth?	☐	☐
Had any head, neck, or jaw injuries?	☐	☐
Ever experienced any of the following problems in your jaw?		
- Clicking	☐	☐
- Pain (joint, ear, side of face)	☐	☐
- Difficulty in opening or closing	☐	☐
- Difficulty in chewing	☐	☐

	YES	**NO**
Frequent headaches?	☐	☐
Clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you had any orthodontic treatments?	☐	☐
Have you ever had prolonged bleeding following extractions?	☐	☐
Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
Have you ever had instruction on the care of your gums?	☐	☐

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Tensas Dental Clinic of any changes in my medical condition or medications during the course of my treatment or at follow up visits.

Signature_____ **Date:** _____

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HIPPA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations, you have the right to revoke this consent in writing, signed by you. However, such a revocation shall no affect any disclosures we have already made in reliance on your prior consent. The practice provides the form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPPA)

We participate in a Health Information Exchange (HIE). When you seek treatment at an organization participating in a HIE, your health information from other facilities where you have received medical treatment is accessible to our providers. You have the right to opt out of this exchange. If you choose to opt out, your health information will not be accessible even in an emergency situation.

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I AUTHORIZE THAT YOUR OFFICE MAY CONTACT ME IN THE FOLLOWING MANNER:

Home Telephone (Check all that apply)
☐ Ok to leave message on machine with detailed message and call-back number
or
☐ Ok to leave message with call-back number only.
☐ Ok to leave message with a family member. *(Who*_____*)*

Work Telephone (Check all that apply)
☐ Ok to leave message on machine with detailed message and call-back number
or
☐ Ok to leave message with call-back number only.
☐ Ok to leave message with a co-worker. *(Who*_____*)*

Cellphone (Check all that apply)
☐ Ok to leave message on voicemail with detailed message and call-back number
or
☐ Ok to leave message with call-back number only.

Signature of Patient or Guardian_____Date:_____

Witness (Practice Representative)_____Date:_____