Tensas Dental Clinic
Quality Healthcare for Everyone.

PATIENT PAPERWORK

PATIENT INFORMATION

Today's date:_____

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Mailing Address:_____ City_____ State_____ ZIP_____

Physical Address: _____ City_____ State_____ ZIP_____

SS#:_____ Birthdate:_____ ☐ Male ☐ Female

Home #:_____ Work #:_____ Cell#:_____

Email Address: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Care Physician *(Shown on Insurance Card)*:_____

Race: *(check one)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ More than one Race

Ethnicity: *(check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RESPONSIBLE PARTY

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Home #:_____ Work #:_____ Cell#: _____

Billing Address:_____

SS#:_____ Birthdate:_____ Male/Female_____

Relationship to Patient:_____

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

His/Her Name:_____ Relation:_____

Home #:_____ Work #:_____ Cell#:_____

FINANCIAL INFORMATION

☐ **Medicaid (dental) #:**_____ ☐ **Medicare #:**_____

☐ **Private/Other Insurance Name**_____

Policy #:_____ Group #:_____ Effective Date:_____

Name of policy holder:_____ Relation:_____

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

Dental Coverage? ☐ **No** ☐ **Yes**

☐ **No Insurance**

PHARMACY: _____ Street:_____ Phone: _____

Tensas Dental Clinic
Quality Healthcare for Everyone.

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	☐	☐

CADRIOVASCULAR	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 Disformity	☐	☐
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:** _____

Tensas Dental Clinic
Quality Healthcare for Everyone.

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)

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 YOU 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:_____