

New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Do you accept text? yes no Email: _____
Sex: Male Female Marital Status: Single Married Divorced Widowed
Employer or School: _____ Phone: _____
Person to contact in case of emergency: _____ Phone: _____

Dental Insurance

Insurance Company: _____ Phone#: _____
Member ID or SSN: _____ Group #: _____
Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance Coverage (if applies)

Insurance Company: _____ Phone#: _____
Member ID or SSN: _____ Group #: _____
Subscriber's Name: _____ Subscriber's DOB: _____

Dental History

Reason for today's visit: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problems with the following:

- Bad breath Loose teeth or broken fillings Bleeding gums Sores or growth in your mouth
 Periodontal Treatment Clicking or popping jaw Sensitivity to cold, hot or sweets
 Food collection between certain teeth Sensitivity when biting Grinding teeth

How often do you floss: _____ How often do you brush: _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever had any serious illness or operations? Yes No

If yes, describe: _____

Have you ever had a blood transfusion? Yes No

If yes, approximate dates: _____

Women: Are you pregnant? Yes No Are you nursing? Yes No Taking birth control? Yes No

Check if you have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory treatment |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial joints, pins, etc. | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Bleeding abnormally | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV AIDS | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> |

List of medications you are currently taking: _____

Please list drug allergies: _____

To the best of knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or a minor child has a change in health.

Patient or Guardian Signature: _____ *Date:* _____

*Cameron Comprehensive Dentistry
116 E. 1st. St.
Cameron, Texas 76520*

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.

I, hereby consent and acknowledge that I have reviewed policies and agree to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____

Date _____

Relationship to Patient _____