PARKWAY
DENTAL

PERSONAL INFORMATION

Name			Date of Birth		
Address			SSN		
City		State		Zip	
Home Phone		Cell Phone			
Work Phone		Email			
Employer		Occupation			
Spouse Name		Spouse Phone			

DENTAL INSURANCE INFORMATION

Insurance		Insurance Phone	
Group #		Subscriber ID#	
Subscriber Employer		Subscriber Name	
Subscriber SSN		Subscriber Date of Birth	

MEDICAL HISTORY

Do you have or have you ever had any of the following diseases or medical conditions: (Please circle yes or no)

Yes	No	AIDS/HIV	Yes	No	Cancer/Leukemia					
Yes	No	Diabetes	Yes	No	Gout					
Yes	No	Heart Disease	Yes	No	Hepatitis	A	B	C	Other	
If yes,		What Type:_____	Yes	No	High Blood Pressure					
Yes	No	Hyper / Hypo Thyroid (circle which)	Yes	No	Lung Disease or Pneumonia					
Yes	No	Joint Replacement	Yes	No	Mononucleosis					
Yes	No	Brain Injury	Yes	No	Hearing Aids					
Yes	No	Tuberculosis	Yes	No	STDs (Syphilis, Herpes, Gonorrhea)					
Yes	No	Asthma	Yes	No	Heart Murmurs (Mitral Valve Prolapse)					
Yes	No	Kidney Problems	Yes	No	Arthritis or Rheumatism					
Yes	No	Bleeding Disorders	Yes	No	Stroke					
Yes	No	Sinus/Ear Problems	Yes	No	Artificial Valve or Pace Maker | Date Placement:					
Yes	No	Jaw Pain or Disorder	Yes	No	Lupus / Autoimmune					
Yes	No	Osteoporosis	Yes	No	Ulcers/Colitis					
Yes	No	Depression/ Anxiety	Yes	No	Liver Disease					
Yes	No	Headaches/Migraines	Yes	No	Seizures					
Yes	No	Currently Pregnant	Yes	No	Hormone Replacement					

ALLERGIES (PLEASE CHECK IF YES)

	Penicillin		Metals		Aspirin		LATEX		Sulfa
	Tetracycline		Hayfever		Erythromycin		Codeine		Other
Comments:								Please list:	

MEDICATIONS OR SUPPLEMENTS

Please list medications or supplements that you are currently taking:	

Please see 2nd page...

GENERAL HEALTH & DENTAL HISTORY

Yes	No	Have you ever been told to pre-medicate prior to dental visits?			
Yes	No	Is your general health good?			
Yes	No	Have you been hospitalized or had a SERIOUS ILLNESS/INJURY in the last three years? *If yes, please tell us why:*			
Yes	No	Are you being treated by a physician now? *For what:*			
Date of last Medical Exam?					
Have you had any trouble with past dental treatment? Please explain:					
Yes	No	Have you had plastic/cosmetic surgery? If yes, for what?			
Yes	No	Tobacco	Cigarettes:	Chew:	
Yes	No	Alcohol	Amount Per Week		
Yes	No	Do you snore?	Do you sleep well and feel rested in the morning?	YES	NO
Yes	No	Have you ever been diagnosed with a sleep disorder? *If yes, please answer the next*			
Yes	No	Are you currently using a C-PAP machine?			

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all fees including any collection costs, attorney costs, and any court costs associated with the payment of fee for service.

The fee that is quoted is for the doctor's time and services, apart from the outcome.

I have read and agree to the above consent.

Signature of Patient or Responsible Party

Date

ACKNOWLEDGMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the *Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices*, and that I may contact this office to obtain a current copy of the practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Signature

Date

Relationship to Patient if Minor