Friedman Family Dentistry

Patient Information (confidential)

Date_______________

Name____
Address____
City __________________________ Zip code__________

Home phone________________________________
Work phone_________________________________
Cell phone__________________________________
email______________________________________

☐ Married
☐ Single
☐ Divorced
☐ Minor

Social Security #_________________________________
Drivers License #_________________________________

Date of Birth ______________________________

Person to contact for emergency and phone #____
Whom may we thank for telling you about us?____

Insurance Information

Insured Name____________________________________
Birthdate of insured______________________________
Name of Employer________________________________
Work Address____________________________________
Insurance Company______________________________
Ins. Co. Address _________________________________

Social Sec. #________________________________
Relationship to patient______________________
Date employed_______________________________
City ________________________ Zip Code_______
Group #_____________________________________
Phone ____________________________________
City ________________________ Zip Code_______

Please provide information for additional dental insurance

Responsible Party Information

Name of person responsible for this account____
(If responsible party is not the patient, please fill out the rest of this section)

Relationship to Patient_____________________________
Address____
Work phone ______________________________________
Social Security # _________________________________

Home phone _____________________________
City ________________________ Zip Code_______
Cell phone _________________________________

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Dental History

Please check all that apply

- ☐ Currently experiencing dentally related pain
- ☐ Gums bleed when brushing
- ☐ Grind teeth
- ☐ Sores or lumps in the mouth
- ☐ Teeth are sensitive to sweets
- ☐ Have had difficult extractions
- ☐ Have had braces
- ☐ Previous injury to mouth or jaw
- ☐ Prolonged bleeding after an extraction

When was your last dental visit?______________________________

For what reason?______________________________

Who provided your previous dental care? ______________________________

What do you like least about the dentist?______________________________

What do you like most about the dentist (if anything)?______________________________

Please rate how you like your own teeth on a scale 1 – 10______________________________

What do you like least about your teeth?______________________________

Are you interested in cosmetic suggestions?______________________________

Authorization and release:

I certify that I have read and fully understand the above information to the best of my knowledge.
I understand that providing false or incorrect information may be dangerous to my health. I have answered the above questions accurately. I authorize the dentist to release any or all information including the diagnosis and records of any examination or treatment rendered to me or the person I am responsible for during th period of such Dental care to third party payors and/or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental care group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services rendered. I agree to be held financially responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is expected at the time service is rendered unless financial arrangements have been made in advance. I further agree to be responsible for all collection fees , court costs, and reasonable attorney fees if this account is turned over to a collection agency or attorney.

Signature______________________________ Date______________________________

Patient______________________________

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Friedman Family Dentistry, P.C.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ______________________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A ______________________

Comments: ______________________

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

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

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Appointment Attendance Policy

In order for us to provide the best possible dental care, we require that you make all scheduled appointment times or cancel 24 hours in advance. A $25.00 fee will be assessed for missed appointments. Appointments cancelled within 24 hours of the appointment time will be considered as a missed appointment. By signing below, you acknowledge that you have read and understand this policy. Feel free to ask any questions or express any concerns pertaining to our policy.

Thank you,
Dr. Friedman and Staff

Signature____ Date________________________________