



Patient Name: _____ Preferred Name: _____

Birth date: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Married Single Divorced

May we email/text you about: Appointments? Yes No

Special Offers? Yes No

Dental Information? Yes No

Name of Employer: _____

Primary Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Subscriber's Social Security #: _____

Secondary Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Subscriber's Social Security #: _____

Emergency Contact Person: _____ Relationship: _____

Phone Number: _____

How did you hear about our office? _____



FINANCIAL AGREEMENT

Payment in full for all charges is required at time of service, unless prior arrangements have been made. If you are unable to make your appointment, please give us more than 24 hours notice. If you fail to show up for your pre-appointed time, or cancel within 24 hours, you may be assessed a \$50 No-show fee.

Responsible Party Signature

INSURANCE FILING

You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We will be happy to file insurance claims for you and do our best to ESTIMATE what they will cover, but you are financially responsible for whatever your insurance company doesn't cover.

Responsible Party Signature

USE OF PHOTOGRAPHS AND IMAGES

I understand that photographs, x-rays and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of research, education, advertisement or publication.

Responsible Party Signature

MEDICAL HISTORY

Do you currently have, or have you ever had any of the following:

Alzheimer's/Dementia	YES	NO	Emphysema	YES	NO	Loud Snoring	YES	NO
Anemia	YES	NO	Epilepsy or Seizures	YES	NO	Low Blood Pressure	YES	NO
Arthritis	YES	NO	Fainting/Dizzy Spells	YES	NO	Mitral Valve Prolapse	YES	NO
Artificial Heart Valve	YES	NO	Frequent Cold Sores	YES	NO	Multiple Sclerosis	YES	NO
Artificial Joints	YES	NO	Glaucoma	YES	NO	Nervousness/Anxiety	YES	NO
Asthma	YES	NO	Heart Defect/Heart Murmur	YES	NO	Psychiatric Treatment	YES	NO
Back Problems	YES	NO	Heart Disease/Attack	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Bone Density Medication	YES	NO	Heart Failure	YES	NO	Severe Allergies/Hives	YES	NO
Bruise Easily	YES	NO	Heart Surgery/Pacemaker	YES	NO	Sickle Cell Disease	YES	NO
Cancer/Leukemia	YES	NO	Hemophilia/bleeding issues	YES	NO	Sinus Trouble	YES	NO
Chemotherapy/Radiation	YES	NO	Hepatitis/Liver Disease	YES	NO	Stroke	YES	NO
Chest Pain	YES	NO	High Blood Pressure	YES	NO	Thyroid Disease	YES	NO
Depression	YES	NO	HIV Positive/AIDS	YES	NO	Use a C-Pap Machine	YES	NO
Diabetes	YES	NO	Kidney Disease	YES	NO	Yellow Jaundice	YES	NO
Difficulties Breathing	YES	NO	Loss of Appetite	YES	NO	Adverse reaction to anesthetic?	YES	NO
Drug/Alcohol Addiction	YES	NO	Loss of Sleep	YES	NO			

Is there any other medical information not listed that we should know about?

Are you **pregnant/trying to become pregnant**? YES NO Are you taking **birth control**? YES NO
 Are you currently taking **blood thinners**? YES NO Do you have a **LATEX** allergy? YES NO
 Do you use tobacco products? YES NO If yes, how long? _____ How often? _____

List any medications or substances that you are **ALLERGIC** to:

List all medications that you are taking:

DENTAL HISTORY

Do you pre-medicate for dental visits?	YES	NO	Do you get food caught between teeth?	YES	NO
Do you have dental fear/dental anxiety?	YES	NO	Are you self-conscious about your teeth?	YES	NO
Are you satisfied with your previous dentistry?	YES	NO	Does your jaw often feel tired or sore?	YES	NO
Have you ever had a bad dental experience?	YES	NO	Do you experience TMJ issues?	YES	NO
Do your gums bleed easily?	YES	NO	Are you aware of clenching or grinding?	YES	NO
Are your teeth sensitive to hot/cold/sweets	YES	NO	Have you ever had braces?	YES	NO

What prompted you to seek dental care at this time? _____

Approximately how long has it been since your last dental cleaning and exam? _____

What if anything would you like to change about the appearance of your teeth?

Whiter Straighter Longer Shorter Shaped Differently Nothing

I acknowledge that all of the above information is accurate to the best of my knowledge. I authorize this office and its trained staff to take x-rays and other diagnostic aids needed to make proper diagnosis of my dental needs. I authorize this office and its trained staff to perform all forms of treatment as indicated. I understand that the use of anesthetic agents will be used when indicated and that this embodies certain risk. I give my permission to release medical/dental information as needed to receive proper treatment from other health care providers.

Signature of Patient/Parent or Guardian

Date

Dr Initials

Date

HOLLIS FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

