PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N
Address_____
Work Phone_____ Home Phone_____Cell Phone _____
Email_____
How did you hear about us?
_____
(If someone referred you here, please write down their name so we can thank them.)

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name_____Subscriber ID # _____
Insurance Company _____Phone_____
Employer_____Group Name_____Group #_____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name_____Subscriber ID # _____
Insurance Company _____Phone_____
Employer_____Group Name_____Group #_____
Please present insurance card to receptionist.

MEDICAL HISTORY

Name of your Medical Doctor:_____

Address/City/State_____

Emergency Contact_____ Phone_____Relationship_____

Are you under care of physician right now? Why?_____

Have you had a serious illness, operation or been hospitalized in past? Yes ▢ NO ▢

If yes, Explain_____

Are you Taking any prescribed **medications** or other OTC meds ? Please List all

_____

_____

Do you use Tobacco: Yes ▢ NO ▢

Are you use Control substance (drugs): Yes ▢ NO ▢

Do you drink Alcohol: Yes ▢ NO ▢

Do you have congenital Heart Disease: Yes ▢ NO ▢

Do you have artificial Heart Valve: Yes ▢ NO ▢

Do you have previous infective endocarditis: Yes ▢ NO ▢

Do you Heart Transplant Yes ▢ NO ▢

Do you have Joint Replacement Yes ▢ NO ▢

Are you taking any taking Oral or IV bisphosphonates (Fosamax, Actonel, Aredia, Zometa etc). Yes ▢ NO ▢

Allergies:

Local anesthetics	Yes ▢ NO ▢	Aspirin	Yes ▢ NO ▢	Penicillin	Yes ▢ NO ▢
NSAIDs	Yes ▢ NO ▢	Codeine	Yes ▢ NO ▢	Latex	Yes ▢ NO ▢
Iodine	Yes ▢ NO ▢	Sulfa drugs	Yes ▢ NO ▢	Hay fever/seasonal	Yes ▢ NO ▢

Others:_____

Women only: Pregnant/Trying to be pregnant Yes ▢ NO ▢. Nursing: Yes ▢ NO ▢.

Birth control pills/Hormone replacement Yes ▢ NO ▢

Please make your response to indicate you have/had or not any **medical condition** listed. Y for yes and N for no:

Medical Condition	Y	N		Y	N		Y	N
Heart Disease			Hemophilia			Thyroid Problems		
Angina			AIDS/HIV positive			Stroke		
Congestive heart failure			Arthritis			Hepatitis		
Damaged Heart Valves			Autoimmune disease			Liver disease/failure		
Heart Attack			Rheumatoid Arthritis			Epilepsy		
High Blood Pressure			Lupus			Fainting spells or seizures		
Low Blood Pressure			Asthma			Neurological disease		
Congenital Heart Defect			COPD/Emphysema/Bronchitis			Sleep Disorder		
Mitral Valve Prolapse			Lung Disease			Mental Health disorder		
Cardiac Pacemaker			TB/Tuberculosis			Kidney problems		
Rheumatic fever			Cancer			Dialysis		
Rheumatic heart disease			Chest pain on exertion			Osteoporosis		
Abnormal bleeding			Diabetes			Severe Headache/Migraine		
Anemia			Stomach problems?GI disease			Sexually transmitted disease		
Blood Transfusion			Heartburn/ Ulcers/Reflux			Rapid weight loss		

If you have any other medical condition please specify: _____

_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain? _____

Signature_____Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

Expressions Family Dental
* You May Refuse to Sign This Acknowledgment*

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Print Name of Patient:_____

Signature:_____Date:_____

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above)

Authorization for Use or Disclosure of Patient Information

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

- ❑ All treatment information
- ❑ Information specifically to certain treatment. Please specify

_____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying BridgeHampton Dental in writing.

Signature of Patient (or Patient's Representative) _____Date: _____

Printed Name of Patient (or Patient's Representative) _____

I Authorize contact from this office to confirm my appointments and billing information via:

- ❑ Cell Phone Confirmation
- ❑ Email Confirmation
- ❑ Text Message to my Cell Phone
- ❑ Work Phone Confirmation
- ❑ Home Phone Confirmation
- ❑ **Any of the Above**

I Authorize information about my health/treatment be conveyed via:

- ❑ Cell Phone Confirmation
- ❑ Email Confirmation
- ❑ Text Message to my Cell Phone
- ❑ Work Phone Confirmation
- ❑ Home Phone Confirmation
- ❑ **Any of the Above**

Signature_____Date_____

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above)

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)_____