NAME:________________________________________

## Patient Basic Information

Legal First Name____________________ Nickname____________________

Middle Initial______ Last Name_____________________________

Birth Date_______________ Gender ___________

SSN_________________________ Martial Status ______________________

## Patient Contact Information

Address_______________________________________ Suite/Apt__________

City ________________________State______________ Zip code__________

EMAIL ________________________________

Home Phone __________________ Cell Phone ________________

Who is responsible for account? ________________________ Relationship: ______________________

Emergency Contact: ___________________ Phone Number: __________________

Relationship: ______________________

## Patient Primary Insurance

Subscriber (Insured) Employer ________________________

Subscriber Name ____________________ D.O.B ________________

Social Security # ___________________________________

Insurance Co.__________________________ Phone # __________________________________

ID # ________________________________ Group # ____________________________

## Secondary Insurance( if applicable )

Subscriber (Insured) Employer ________________________

Subscriber Name ____________________ D.O.B ________________

Social Security # ___________________________________

Insurance Co.__________________________ Phone # __________________________________

ID # ________________________________ Group # ____________________________

NAME:______________________________________________

## HIPAA Information and Consent

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A notice of Privacy practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices, which include:

- Protected health information may be disclosed or used for treatment in our office or with any specialist office that you may be referred to, payment, and correspondence with insurance companies or health care operations. It may also be used in correspondence with the dental lab, if needed.
- Authorization is required for disclosure of information to family members, care takers or significant others.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

I hereby authorize Drs. Burau High Tech and Cosmetic Family Dentistry (Drs. Burau, P.C.) to release my patient health information as described below:

| | | Type of Information Allowed to Disclose (Check one or both) | | Method of Disclosure (Check one or both) | |
|---|---|---|---|---|---|
| Name | Relationship | Medical | Billing | By Phone | In Person |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change out notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

Name_____________________________________ Date _____________

NAME:_______________________________________________

## Medical and Dental Information

Your Name: _________________________

Medical Doctor's Name: _____________________ City: ___________________

Are you now under the care of a physician? YES NO

**Do you have, or have you had any of the following:**

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Diabetes | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Arthritis | ☐ Epilepsy | ☐ Jaw Pain | ☐ Swelling of feet or ankles |
| ☐ Artificial Heart Valves | ☐ Fainting | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Artificial Joints | ☐ Glaucoma | ☐ Liver Disease | ☐ Tobacco Habit |
| ☐ Asthma | ☐ Headaches | ☐ Mitra Valve Prolapse | ☐ Tuberculosis |
| ☐ Back Problems | ☐ Heart Murmur | ☐ Pace Maker | ☐ Ulcer |
| ☐ Blood Disease | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Cancer | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ |
| ☐ Chemical Dependency | ☐ Hepatitis | ☐ Shortness of Breath | ☐ |
| ☐ Circulatory Problems | ☐ High Blood Pressure | ☐ Sleep Apnea | ☐ Other_________________ |

Have you ever had a reaction to epinephrine? _____________________

History of other serious illness, hospitalization or accident? ________________

Do you have additional medical conditions or concerns? ___________________

Have you had any changes in your general health lately? __________________

Have you ever taken an antibiotic prior to dental treatment? (If yes, please list type)

_____________________________________________________

## Medication Reconciliation

Current Medications you are Taking:

______________________________________________________________________

______________________________________________________________________

## Allergies

Do you have any allergies : YES NO

If yes , please list: ________________________________________________________

NAME:_______________________________________

## Bisphosphonates (Medications used to treat osteoporosis and similar diseases.)

Have you ever taken these medications: YES NO
If yes ,please circle
Alendronate (fosamax) Risedronate (actonel) bandronate (Boniva)

## Smoking Status

Do you currently smoke: YES NO

## Women

Are you pregnant or suspect you may be: YES NO

## Dental History

When was your last dental visit? _______________________________

How frequently do you brush your teeth? _______________________________

How frequently do you floss your teeth? _______________________________

What is the nature of today's visit? _______________________________

Are you nervous about dental treatment? _______________________________

Have you ever had orthodontic treatment? _______________________________

Are you happy with your smile? YES NO

Do you clench or grind your teeth? YES NO

Have you ever been treated for gum disease? YES NO

Do your gums bleed when you brush or Floss? YES NO

Are any of your teeth currently causing you pain? YES NO

Have you ever had any periodontal treatment? YES NO

Are you concerned with loose teeth or teeth loosening? YES NO

Do you have any dental implants, dentures, or partials? YES NO

Have you been told you snore? YES NO
If yes, please comment: _______________________________

Have you been treated for Sleep Apnea? YES NO
If yes, please comment: _______________________________

## How Did You Hear About Us?

How did you hear about us? _______________________________