# Welcome

## ABOUT YOU

Today's Date: _____ E-mail Address: _____

**Name:** _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

**Home Address:** _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

**Neighbor or Relative not living with you**

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

**Person Responsible for Account if other than yourself**

Name: _____ Relation: _____ Home Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

## DENTAL HISTORY

**Why have you come to the dentist today?** _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ N Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

**Are you happy with the way your smile looks?** ❑ Yes ❑ No

If not, what would you change? _____

_____

## MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: _____

Physician's Name: _____

Address: _____ Phone #: (___) _____

**Your current physical health is:** ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

**Are you allergic to any of the following?**

| | | |
|---|---|---|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry / Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | Y N Other |

Please list additional drugs/materials that cause allergic reactions: _____

_____

**For Women:** Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

**Are you taking any of the following?**

| | | | |
|---|---|---|---|
| Y N Acetaminophen | Y N Blood Thinners | Y N Digitalis/Heart Medication | Y N Recreational Drugs |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Insulin/Diabetes Drugs | Y N Steroids/Cortisone |
| Y N Antihistamines | Y N Cold Remedies | Y N Nitroglycerin | Y N Thyroid Medicine |
| Y N Aspirin | | | Y N Tranquilizers |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: _____

_____

**Do you or have you experienced the following?**

| | | | | |
|---|---|---|---|---|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Liver Disease | Y N Seizures |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Low Blood Pressure | Y N Shingles |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Lupus | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Mitral Valve Prolapse | Y N Sinus Problems |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Hemophilia | Y N Osteoporosis/Paget's Disease | Y N Steroid Therapy |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Stroke |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Treatment | Y N Tonsillitis |
| Y N Cancer | Y N Fever Blisters | Y N HIV$^+$/AIDS | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized for Any Reason | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chicken Pox | Y N Hay Fever | Y N Kidney Problems | Y N Scarlet Fever | Y N Venereal Disease |

Please list any serious medical condition(s) that you have experienced: _____

## AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

**PAYMENT IS DUE AT TIME OF SERVICE**

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

# HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**Signed this _____ day of _____, 20__.**

**Print Patient Name_____**

**Relationship to Patient_____**

**Signature_____**

Renk
LAS VEGAS
PROSTHODONTICS

JOSHUA A. RENK, DDS, MSD
MARCO T. PADILLA, DMD,MS