

John T. Veale D.M.D., M.P.H.

Peter G. Veale D.M.D.

Patient Information

Name: (First) _____ (Last) _____ (M) ___ (Preferred Name) _____

Address: (Street) _____

(City) _____ (State) _____ (Zip) _____

Date of Birth: _____ Male ___ Female ___
Single ___ Married ___ Divorced ___ Widowed ___

Phone: Home (____) _____
Work (____) _____ Social Security # _____
Cell (____) _____ Email: _____

Pharmacy: (Store) _____ (Phone) _____ (Location) _____

How did you hear about us?

Patient Referral (Name) _____
Internet ___ Walk-In ___ Insurance _____

Are you currently a full-time college student? No ___ Yes ___ Name of College _____

Primary Dental Insurance

Subscriber Name _____ ID# _____ D.O.B. _____
Insurance Co. _____ Insurance Co. Phone # _____
Employer _____ Relationship to Patient _____

Secondary Dental Insurance

Subscriber Name _____ ID# _____ D.O.B. _____
Insurance Co. _____ Insurance Co. Phone # _____
Employer _____ Relationship to Patient _____

Dental History (Please indicate if you have had any of the following)

Reason for today's visit _____ Date of last Dental Visit _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Orthodontic Treatment |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Food Collection | <input type="checkbox"/> Pain Around Ear |
| <input type="checkbox"/> Blisters on Lips/Mouth | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Burning Sensation Tongue | <input type="checkbox"/> Gums Swollen/Tender | <input type="checkbox"/> Sensitivity to Cold/Hot |
| <input type="checkbox"/> Chew on One Side of Mouth | <input type="checkbox"/> Jaw Pain or Tiredness | <input type="checkbox"/> Sensitivity to Sweets/Biting |
| <input type="checkbox"/> Cigarette, Pipe, Cigar Smoker | <input type="checkbox"/> Lip or Cheek Biting | <input type="checkbox"/> Sores or Growths in mouth |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Loose Teeth/Fillings | <input type="checkbox"/> How Often Do You Floss |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> How Often Do You Brush |

The Information on this page is correct to the best of my knowledge

Signature _____ Print _____ Date _____

John T. Veale D.M.D, M.P.H.

Peter G. Veale D.M.D.

Office use only:

Provider _____ Date _____

Name _____ Date of Birth _____ SS# _____ Date _____

**** Please list any medications you are currently taking (note: if you have a written list, we can take a photocopy)

Has a physician advised you an antibiotic premedication is needed for dental treatment? ___ Yes ___ No

Have you had a serious illness or operation? ___ Yes ___ No (If yes, please describe) _____

Emergency Contact Person _____ Relation _____ Phone # _____

Medical History (Please indicate if you have had any of the following)

- Do you smoke/use tobacco? ___ Y ___ N _ Abnormal Bleeding _ Fainting/Dizzy _ Pacemaker
- Are you taking birth control? ___ Y ___ N _ Alcohol Abuse _ Fever Blisters _ Psychiatric Care
- Are you pregnant? ___ Y ___ N _ Anemia _ Glaucoma _ Radiation Treatment
- Are you nursing? ___ Y ___ N _ Angina Pectoris _ Headaches _ Respiratory Disease

ALLERGIES

- _ Aspirin
- _ Barbiturates (Sleeping Pills)
- _ Codeine
- _ Dental Anesthetics
- _ Erythromycin
- _ Iodine
- _ Latex
- _ Metals
- _ Penicillin
- _ Seasonal Allergies
- _ Sulfa
- _ Tetracycline
- _ Other Allergies _____
- _____
- _____
- _____
- _____
- _ Arthritis
- _ Artificial Heart Valve
- _ Asthma
- _ Back Problems
- _ Blood Disease
- _ Blood Transfusion
- _ Cancer
- _ Chemotherapy
- _ Circulatory Problems
- _ Colitis
- _ Congenital Heart Defect
- _ Cortisone Treatments
- _ Cough Persistent/Bloody
- _ Diabetes
- _ Difficulty Breathing
- _ Drug Abuse
- _ Emphysema
- _ Epilepsy
- _ Facial Surgery
- _ Heart Attack
- _ Heart Murmur
- _ Heart Problems
- _ Heart Surgery
- _ Hemophilia
- _ Hepatitis A
- _ Hepatitis B
- _ Hepatitis C
- _ Herpes
- _ High Blood Pressure
- _ HIV/AIDS
- _ Jaundice
- _ Jaw Pain
- _ Joint Replacement
- _ Kidney Problems
- _ Liver Disease
- _ Low Blood Pressure
- _ Mitral Valve Prolapse
- _ Nervous Problems
- _ Rheumatic Fever
- _ Scarlet Fever
- _ Seizures
- _ S.T.D.
- _ Shingles
- _ Shortness of Breath
- _ Sickle Cell Disease
- _ Sinus Problems
- _ Skin Rash
- _ Special Diet
- _ Stroke
- _ Swollen Feet/Ankles
- _ Swollen Neck Glands
- _ Thyroid Problems
- _ Tonsillitis
- _ Tuberculosis
- _ Tumor on Head/Neck
- _ Ulcers
- _ Other Conditions ___

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental service agreed between doctor and patient and/or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all the treatment and services rendered are my responsibility.

Signature _____ Print Name _____ Date _____

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Patient HIPAA Consent Form

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help ensure that PHI is kept private. This rule was also established in order to provide a standard for health care operation.

We want you to know that we respect the privacy of your medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We Support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but not limited to laboratories, pharmacies and other medical offices. As such, we may need to discuss PHI for purposes of treatment, payment and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. This refusal must be in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of your PHI. This refusal must be in writing. However, you may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You may receive a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our office if you have any objections to this consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____