Welcome to Urbana Family Dental!

To help us better serve you, please fill out this form completely. If you have any questions or need assistance, please ask us and we will help.

Patient Name: ______________________________ **Today's Date:** ____________

Preferred Name: ______________________ / ☐ **Male** ☐ **Female** / ☐ **Married** ☐ **Single** / ☐ **Child**

Patient's SS#: ______-______-________ **Birth Date:** ____/____/_____ **Home Phone:** ________________

Patient's Address: ______________________________ **Cell Phone:** ________________

City: ________________ **Zip code :** ________________ **Email:** ________________

Patient/(or Parent if under 18) : Employer ________________ **Work #** ________________

Employer's Address: ______________________________

Spouse's Name: ________________ **Contact Number**: ________________

Contact Person (who does not live with you) Name: ________________ **Phone Number:** ________________

Responsible Party: If patient is a child or under the age of 18 or if another adult is responsible for the account

Name of Person Responsible for Account: ________________ **Relationship to Patient**: ________________

SS#: ______-______-______ **Birth Date**: ______/______/______ **Home Phone:** ________________

Insurance information: **please provide us with your dental insurance card so we may make a copy**

Name of Primary Insured: ________________ _**Relationship to Patient**: ________________

SS#: ______-______-________ **Insured Birth Date:** ____/____/______ **Home Phone:** ________________

Employer: ______________________________ **Work Phone:** ________________

Insurance Company: ________________ **Group #** ____________ **Policy #:** ________________

Urbana Family Dental

ACKNOWLEDGEMENT **OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (or parent if under 18) ______________________, **have been offered a copy of this office's Notice of Privacy Practices.**

____
{Please Print Name}

____
{Signature}

____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself or your child covered under the Privacy Act other than yourself.

I, **(or parent if under 18)** ____________ ____________, **authorize** the following person(s) to have access to information covered under the Privacy Practice regarding myself.

______________________ ______________________
{Please Print Name} Relationship

______________________ ______________________
{Please Print Name} Relationship

Tell us how you heard about our office? ______________________

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)** **© 2002 American Dental Association All Rights Reserved Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written**

approval of the American Dental Association. This form is educational only, does not constitute legal advice, and covers only federal, not slate, law (August 14, 2002)

Patient Medical History

Name of Physician: ___________________________________ Last Exam: _________________ Office Phone: ______________

1. Are you under medical treatment now? ☐ Yes ☐ No
   If yes, please explain: ___________________________
   ____
2. Do you smoke tobacco products? ☐ Yes ☐ No
3. Do you use controlled substances? ☐ Yes ☐ No
4. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
   If yes, please explain:
   ____
   ____

Medications -

Please document all other medications you are currently taking and their purpose:

Do you have or have you had any of the following? Check all that apply

Allergies:

- Codeine
- Iodine
- Latex
- Metals
- Penicillin
- Sulfa
- Other_____________

- Aids/HIV
- Anemia/Hemophilia
- Arthritis
- Artificial/joints
  - Date_____________
  - Location:__________
- Asthma
- Behavioral Disorder
  - Explain:___________
    ____
    ____
- Blood Disease
- Cancer
  - Type_____________
- Currently Pregnant
  - Due date___________
- Diabetes
  - Type_____________

- Drug Addiction
- Epilepsy/Seizures
- Excessive Bleeding
- Fainting/Dizziness
- Glaucoma
- Heart attack
- Heart Disease
- Heart murmur
- Hepatitis
- High Blood pressure
- HPV
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Migraines
- Mitral valve prolapse
- Nervous Disorders
- Nursing
- Osteoporosis
- Pacemaker
- Physical Disabilities
  - Explain:___________
    ____
    ____

- Pre-medication
  - Reason:___________
    ____
    ____
- Psychiatric Care
  - Explain:___________
    ____
    ____
- Radiation
- Respiratory
- Sinus problems
- Skin Rash/Hives
- Spina Bifida
- Stomach problems
- TMJ
- Thyroid problems
- Tuberculosis
- Ulcers
- Stroke
- Other_____________________
  ____
  ____

☐ **NONE of the above**

Patient Dental History

Name of Previous Dentist ____ Date of Last Exam or Cleaning ___________________________

1. Have you ever had any complications during/following dental treatment? ☐ Yes ☐ No
2. Are your teeth sensitive to hot, cold or sweet liquids/foods? ☐ Yes ☐ No
3. Do you have pain in your teeth or a certain tooth? ☐ Yes ☐ No
4. Have you ever had clicking or pain in your jaws or difficulty opening or closing? ☐ Yes ☐ No
5. Do you have frequent headaches? ☐ Yes ☐ No
6. Do you clench or grind your teeth? ☐ Yes ☐ No
7. Have you ever had a difficult extraction(s) or prolonged bleeding following an extraction in the past? ☐ Yes ☐ No
8. Have you had any orthodontic treatment (braces)? ☐ Yes ☐ No
9. Do you like your smile? ☐ Yes ☐ No
10. If you could change one thing about your smile or teeth, what would it be? ______________________

Authorization and Release:

I certify that I have read, answered and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also authorize the dentist(s) and/or dental office to release any information to third party payers and/or other healthcare practitioners.

Patient/(or Parent if under 18) Signature

x___________________________________