DARAB & RICHARDSON

Welcome To Our Practice

Date ______________________

Patient (Mr., Mrs., Ms., Dr.) ______________________
Last First Middle Nickname

❏ Male ❏ Female
Mailing ______________________ Street ______________________
City ______________________ State __________ Zip __________
Home # ______________ Work# ______________ Ext. __________
Date of Birth ______________ Cell # ______________
Social Security Number ______________ Employer ______________
Which phone # is better to reach you during the day? ❏ Home ❏ Work ❏ Cellular ❏ Email __________
Have you ever been a patient of our practice? ❏ Yes ❏ No

Who will be responsible for your account? ❏ Self ❏ Spouse ❏ Father ❏ Mother
Marital Status? ❏ Married ❏ Divorced ❏ Legally Separated ❏ Widowed ❏ Single
Name ______________________
Last First Middle Nickname
Mailing ______________________ Street ______________________
City ______________________ State __________ Zip __________
Home# ______________ Work# ______________ Ext. __________
Cell# ______________ Employer ______________
Social Security Number ______________ Date of Birth ______________

Whom may we thank for referring you to our office?
____
Dentist ______________________
Medical Doctor ______________________

Name of relative or friend not living with you.
Name ______________________
Address ______________________
Phone # ______________ Relation __________

Insurance Information

Patient: Student: ❏ Full Time ❏ Part Time School Name/Address ______________________
Marital Status: ❏ Married ❏ Divorced ❏ Legally Separated ❏ Widowed ❏ Single
Employed: ❏ Full Time ❏ Part Time ❏ Retired

Primary Dental Insurance Company

Employer ______________________
Address ______________________
Phone # ______________ # of Years Employed ______
Insurance Co. Name ______________________
Address ______________________
____
Phone # ______________ Group # __________
Insured Party ______________ Relation __________
❏ Male ❏ Female Date of Birth ______________
Street ______________________
City ______________ State ________ Zip ________
Home # ______________ SS# ______________

Primary Medical Insurance Company

Employer ______________________
Address ______________________
Phone # ______________ # of Years Employed ______
Insurance Co. Name ______________________
Address ______________________
____
Phone # ______________ Group # __________
Insured Party ______________ Relation __________
❏ Male ❏ Female Date of Birth ______________
Street ______________________
City ______________ State ________ Zip ________
Home # ______________ SS# ______________

I attest these are the only insurance policies I am aware of. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize and direct payment of any benefit payable to me directly to the treating physician or practice.

Policy Holder's Signature ______________________________

If you have a secondary insurance policy, see page 2 of this form.

Secondary Dental Insurance Company

Employer ______________________________________

Address _______________________________________

Phone # ________________ # of Years Employed ____

Insurance Co. Name _____________________________

Address _______________________________________

____

Phone # __________________ Group # _____________

Insured Party __________________ Relation _________

❏ Male ❏ Female Date of Birth _________________

Street ____

City ____________________ State ________ Zip _______

Phone # _________________ SS# _________________

Secondary Medical Insurance Company

Employer ______________________________________

Address _______________________________________

Phone # ________________ # of Years Employed ____

Insurance Co. Name _____________________________

Address _______________________________________

____

Phone # __________________ Group # _____________

Insured Party __________________ Relation _________

❏ Male ❏ Female Date of Birth _________________

Street ____

City ____________________ State ________ Zip _______

Phone # _________________ SS# _________________

Updated Information:

_______________________________________ _______________

Signature Date

_______________________________________ _______________

Signature Date

_______________________________________ _______________

Signature Date

_______________________________________ _______________

Signature Date

HEALTH HISTORY

PATIENT'S NAME _______________ DATE OF BIRTH _______________ DATE _______________

Answer all questions by checking No or Yes **All responses are kept confidential**

❑No ❑Yes Are you in good health?
❑No ❑Yes Has there been any change in your general health in the past year?
Date of last physical exam ___________________
❑No ❑Yes Are you now under a physician's care for a particular problem?
Physician's name ___________________
Phone Number ___________________
❑No ❑Yes Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe
____
____
Height ________ Weight ________ Age ______

DO YOU HAVE OR HAVE YOU EVER HAD

❑No ❑Yes Rheumatic Fever of Rheumatic Heart Disease?
❑No ❑Yes Congenital Heart Disease or Endocarditis?
❑No ❑Yes Heart Disease (Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Heart Value, MVP)?
❑No ❑Yes Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?
If so, last attack ___________________________
❑No ❑Yes Seizures, Convulsions, Epilepsy, Fainting or Dizziness?
❑No ❑Yes Psychiatric Treatment, Nervous Disorder, Breakdown?
❑No ❑Yes Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?
❑No ❑Yes Liver Disease (Jaundice, Hepatitis)?
❑No ❑Yes Kidney Disease?
❑No ❑Yes Diabetes?
❑No ❑Yes Thyroid Disease (Goiter)?
❑No ❑Yes Arthritis? Bone Disease? Osteoporosis?
❑No ❑Yes Stomach Ulcers or Colitis?
❑No ❑Yes Glaucoma?
❑No ❑Yes Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?
❑No ❑Yes Radiation (X-Ray) treatment for Cancer?
❑No ❑Yes Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?
❑No ❑Yes Sinus or Nasal problems?
❑No ❑Yes Sleep Apnea, Snoring?
❑No ❑Yes Any disease, drug of transplant operation that has depressed your immune system?

ARE YOU USING ANY OF THE FOLLOWING:

❑No ❑Yes Antibiotics?
❑No ❑Yes Anticoagulants (Blood Thinners)?
❑No ❑Yes Aspirin or drugs such as Motrin, Aleve, Ibuprofen?
❑No ❑Yes High Blood Pressure medications?
❑No ❑Yes Steroids (Cortisone, etc.)?
❑No ❑Yes Tranquilizers or Antidepressants?
❑No ❑Yes Insulin or Oral Anti-Diabetic drugs?
❑No ❑Yes Digitalis, Inderal, Nitroglycerin or other heart drug?
❑No ❑Yes Are you taking or *have you ever* taken Bisphosphonates (Fosamax, Actonel, or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers)? How long? ________

Please list (see back) any and all medications taken, including prescription medications, hormonal replacements, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
____
____
____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

❑No ❑Yes Local Anesthesia (Novocaine, etc.)?
❑No ❑Yes Penicillin or other antibiotics?
❑No ❑Yes Sedatives, Barbiturates?
❑No ❑Yes Aspirin or Ibuprofen?
❑No ❑Yes Codeine or other pain killers?
❑No ❑Yes Latex or Rubber Products?
❑No ❑Yes Food allergies (soy, eggs, etc.)?
❑No ❑Yes Other allergies or reactions? Please list:
____
____

❑No ❑Yes Do you smoke or chew Tobacco?
If so, how much per day? _____________
❑No ❑Yes Do you use alcohol?
If so, how much? _________
❑No ❑Yes Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?
❑No ❑Yes Have you had any serious problems associated with any previous dental treatment?
❑No ❑Yes Have you or an immediate family member had any problem associated with intravenous anesthesia?
❑No ❑Yes Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
❑No ❑Yes Do you wish to talk to the doctor privately about anything?

FOR WOMEN ONLY

❑No ❑Yes Are you pregnant, or **is there any chance** you might be Pregnant?
❑No ❑Yes Are you nursing?

It is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use alternate forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date _______________ Signature of Person Completing Health History _______________ Doctor's Initials _______________

Medical Update: I have read my Health History dated ____________ and confirm that it adequately states past and present conditions.

Date _______________ Exceptions or changes _______________ Patient's Signature _______________ Doctor's Initials _______________

Date _______________ Exceptions or changes _______________ Patient's Signature _______________ Doctor's Initials _______________

MEDICATION NAME	MG	DOSAGE	WHEN TAKEN	WHO PRESCRIBES	DATE	INITIALS

MEDICATION UPDATE:

Date	Exceptions or Changes	Patient Signature	Doctor's Initials

DRS. DARAB & RICHARDSON

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the above named practice.

PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner ***(check all that apply)***:

❏ Home or Cell Telephone / Detailed Message

❏ Work Telephone / Detailed Message

❏ Written Communication

❏ Other / Detailed Message (fax / cell / etc.) ______________________________

I allow you to give my clinical and financial information to or answer questions from ***(check all that apply)***:

❏ Spouse: ______________________________

❏ Parent: ______________________________

❏ Child: ______________________________

❏ Other (specify): ______________________________

❏ None

______________________________ ______________________________

Patient Signature (if minor, Parent Signature) Date

______________________________ ______________________________

Print Patient's Name Birth Date