DIAMONDHEAD DENTAL CLINIC
PATIENT INFORMATION

Patient's Name ____ Preferred Name __________________
First Middle Last
SSN ___________________ Birth date _______________ Sex: M F Marital Status: _________________

Home Address ____
Street City State Zip
Home Phone ___________________ Cell Phone ____________________ Work Phone __________________

Employers Name __________________________________Occupation/Position ________________________
Employers Address____

INCASE OF EMERGENCY:
Person to Notify ______________________________________ Relationship to patient __________________
Emergency Phone # ___________________________________

INSURANCE INFORMATION:
Name of Insured _____________________________________ Relationship to patient ___________________
Birthday _________________________ SSN ____________________________
Employers Name _____________________________________ Phone Number _________________________
Name of Insurance Company ____________________________________Phone #_________________________
ID # _____________________________ Group # __________________________

How did you hear about us? ____

GENERAL INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize payment of dental benefits to Diamondhead Dental Clinic for any services provided to me. I understand I am financially responsible for any amount not covered by my insurance. I also authorize release to my insurance company or other official agent any information regarding my dental treatment and billing.

Signature___________________________ Date_____________________________

I authorize Diamondhead Dental Clinic to contact me via e-mail @____
E-mail address

Signature__________________________ Date____________________________

MEDICAL/ DENTAL HISTORY

Name of Previous Dentist____ Phone # ______________________

Date of Last Cleaning and Exam __________________________

Do you wear dentures or partials? _________ If yes, how long ago were they placed? ____________________

Please circle Yes or No for the following questions:

Are you in good health?-- Yes No

Has there been any change in your health in the past year?-- Yes No

My last physical exam was on ________/________/________

Are you now under the care of a physician?--- Yes No

If so, for what condition? ____

The name and address of my physician is: ____

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Have you had any serious illness, operation or hospitalization within the past 5 years?-------- Yes No

Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?-------------------------- Yes No

Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? Yes No

Have you had radiation therapy to the head, neck, or jaws?-- Yes No

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Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic Or natural remedies?-- Yes No

If so, please list:____

____

Please circle if you have or have had any of the following:

High Blood Pressure
Low Blood Pressure
Fainting/ Seizures
Epilepsy/ Convulsions
Diabetes
Kidney Disease
AIDS or HIV Infection
Sexually Trans. Disease:
If yes,list___________
Thyroid Problem
Tuberculosis

Heart Disease
Cardiac Pacemaker
Heart Murmur
Heart Trouble
Anemia
Chest Pains
Heart Attack
Stroke
Arthritis
Joint Replacement/Implant
Stomach Ulcers

Easily Winded
Respiratory Problems
Emphysema
Asthma
Radiation Therapy
Cancer
Leukemia
Hepatitis/ Jaundice
Liver Disease
Mitral Valve Prolapse
Other _______________

Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)
Penicillin
Other Antibiotics ________________
Sulfa Drugs
Barbiturates
Sedatives

Iodine
Aspirin
Any Metals
Latex Rubber
Codeine/ Hydrocodone
Other ________________

Women Only:

Are you pregnant or trying to become pregnant?------------------------------------- Y N

Are you nursing? ---------------------------- Y N

Are you taking birth control pills?-------- Y N

What is the reason/ chief complaint for today's visit? ____

Diamondhead Dental Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received or been offered a copy of this office's Notice of Privacy Practice

______________________________ ______________________ ____________

Signature (Patient or Responsible party) Relationship to patient Date

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ASSIGNMENT OF BENEFITS RELEASE

I understand that I (or my dependent) have insurance coverage and assign directly to Diamondhead Dental Clinic all insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all insurance submissions.

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Signature (Patient or Responsible party)

FINANCIAL AGREEMENT

I understand that Diamondhead Dental Clinic files my insurance claims as a courtesy. If my insurance does not pay for services rendered, I acknowledge and take full responsibility for any and all charges related to NSF checks, interest incurred on balance past due, court cost or attorney fees and other efforts to resolve my account. I accept full responsibility for all charges.

____

Signature (Patient or Responsible party)

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)