PATIENT INFORMATION

(Your health information is important for our records, and will be considered confidential)

Today's Date:_____ SS# _____ Driver Lic#_____

Name: (First)_____(Middle)_____(Last)_____
(Mr., Mrs., Ms., Miss, Dr.)

Local Address: _____City: _____ State: _____ Zip Code: _____

Spouse or Parent's Name:_____Relationship:_____

Employers Name and Address:_____

Whom may we thank for referring you?_____

Person to Contact in Case of Emergency _____Phone Number_____

Cell Phone: _____ Home Phone:_____

Work Phone: _____ E-mail Address:_____

Date of Birth: _____/_____/_____ Age: _____ Gender: Female_____ Male_____

Name and Phone # of the Pharmacy you would like your prescription called into:

Name: _____Phone Number:_____

RESPONSIBLE PARTY:

Name of person responsible for this account:_____

PATIENT DENTAL HISTORY:

Name of previous dentist: _____Location: _____Date of Last Exam_____

What is your present dental problem:_____

Do You Take **PRE-MEDICATION before dental treatment? Yes No What?_____

Reason for PRE-MEDICATION _____

- Do you gums bleed while brushing/flossing? Yes No
- Are your teeth sensitive to hot/cold/sweets? Yes No
- Do you feel pain in any of your teeth? Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you like your smile? Yes No
- Would you like to have whiter teeth? Yes No
- Do you wear dentures or partials? Yes No

What would you like to change about your smile?

_____

_____

_____

PATIENT MEDICAL HISTORY:

Physician _____ Office Phone _____ Date of last exam_____

- Are you under medical treatment now? Yes No
- Do you use tobacco? Yes No
- Do you take aspirin daily? Yes No
- Have you ever been hospitalized for any surgical operation or serious illness within the last 5-yrs? Yes No

Explain_____

Please list any medication(s) you are using:

_____

_____

OVER ⟶

Are you allergic to or have you had any reaction to the following: PLEASE CIRCLE

o	Local Anesthetics (eg. Novocain)	Yes No	Women Only:		
o	Penicillin or other Antibiotics	Yes No	Are you pregnant or think you are?	Yes	No
o	Sulfa Drugs	Yes No	Are you nursing?	Yes	No
o	Barbiturates, Sedatives	Yes No	Are you taking oral contraceptives?	Yes	No
o	Iodine	Yes No	Are you on Hormone Replacement?	Yes	No
o	Aspirin	Yes No			
o	Codeine or other narcotics	Yes No			
o	Latex Rubber	Yes No			
o	Other	Yes No			

If yes on other, please explain _____

- Do you have or have you had any of the following? PLEASE CIRCLE

Heart Murmur	Yes	No	Joint Replacement or Implant	Yes	No	When?_____
Mitral Valve Prolapse	Yes	No	Heart Disease	Yes	No	
Heart Trouble	Yes	No	Heart Attack	Yes	No	
Cardiac Pacemaker	Yes	No	Angina	Yes	No	
Chest Pains	Yes	No	Rheumatic Fever	Yes	No	
Swollen Ankles	Yes	No	Stroke	Yes	No	
High Blood Pressure	Yes	No	Easily Winded/Shortness of Breath	Yes	No	
Low Blood Pressure	Yes	No	Fainting/Seizures	Yes	No	
Asthma	Yes	No	Hay Fever/Allergies	Yes	No	
Frequently Tired	Yes	No	Tuberculosis	Yes	No	
Anemia	Yes	No	Emphysema	Yes	No	
Epilepsy/Convulsions	Yes	No	Glaucoma	Yes	No	
Thyroid Problem	Yes	No	Arthritis	Yes	No	
Diabetes/Insulin	Yes	No	Burning Mouth	Yes	No	
Cancer	Yes	No	Leukemia	Yes	No	
Radiation Therapy	Yes	No	Recent Weight Loss	Yes	No	
Kidney Diseases	Yes	No	Liver Disease	Yes	No	
AIDS or HIV Infection	Yes	No	Hepatitis/A/B/C/Jaundice	Yes	No	
Stomach Troubles/Ulcers	Yes	No	Sexually Transmitted Disease	Yes	No	
Respiratory Problems	Yes	No	Chronic Cough/Hoarseness	Yes	No	
Nervous Disorder	Yes	No	Scarlet Fever/Pneumonia	Yes	No	
Excessive Bleeding following a scratch, cut, or tooth extraction:				Yes	No	

Do you have any disease, condition, or problem not listed above that you think I should know about? If so, explain:

_____

Patient Financial Information:
Thank you for choosing us as your health care provider. We are committed to giving you comfortable, quality treatment. We have asked you to complete our medical and dental history forms so that we can give you the best care possible. Payment is expected at time of visit. Our financial coordinator will be happy to assist you in anyway with your financial options prior to your treatment. I agree to be fully responsible for total payment of procedures performed in this office. If I default and Boulevard Dental Associates has to refer this contract for collection to an attorney, I agree to pay reasonable attorney's fees and actual court costs.

Authorization for Insurance:
I authorize and request my insurance company to pay directly to the dentist listed. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of yourself or my dependents. I am fully aware that my insurance may not cover any treatment and I will be responsible to pay for all treatment performed. I also understand that my insurance company may still send payment directly to me and if this occurs, I will immediately forward this payment to the dental office to be applied towards my and/or dependents bill. Boulevard Dental Associates can only give estimates of insurance coverage and estimates are not a guarantee of payment.

HIPPA Notice of Privacy Practices (Health Insurance Portability & Accountability Act):
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions regarding the privacy practices, please ask to speak with our HIPAA Compliance Officer in person or by calling (772) 337-1111. HIPAA notice of Privacy Practice form is available upon request.

AUTHORIZATION & RELEASE: I certify that I have read and understand the above information and have answered accurately to the best of my knowledge. I authorize the dentist to release any information regarding the dental history and treatment. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that this office is in compliance with the Health Insurance Portability and Accountability Act (HIPPA) privacy policies.

X_____ **Date**: _____

Signature of Patient (or Parent of Minor)