Augusta Dental Center

PATIENT HISTORY INFORMATION

Patient ID #
For office use:

Name:_____
(first name) (middle name) (last name)

Sex: ____M____F Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____

Street Address:_____

City:_____ State:_____ Zip:_____

E-Mail:_____ Home Phone:_____ Work Phone:_____

Cell:_____ Emergency Contact Name & Phone:_____

Race: ___African American ___Asian American ___Caucasian/White ___Hispanic ___Other

Name of Family Physician:_____ City:_____ State:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- What is your reason for today's visit?_____

  _____

- Have you received treatment in our office previously? YES NO If so, when?_____

- How did you first learn about our affiliated dental practice providing Affordable Dentures? (circle one)

  1. Magazine 2. Newspaper 3. Radio 4. Billboards/Sign 5. Brochure/Mail
  6. Television 7. Yellow Pages 8. Friend/Relative 9. Internet/Web Site 10. Other Doctor
  11. Outside Agency

- Did you call our toll-free information service (1-800-DENTURE) YES NO

- May we provide your name to denture product companies who may wish to send you information on their products? YES NO

- May we contact you with information about special offers and new services we may offer at Affordable Dentures? YES NO If answer is YES, what is the best way to contact you?

(Please circle all methods of communication that you prefer below.)

Mail **Phone** **Email**

Do you have commercial dental insurance? YES NO Name of Insurance:_____

If yes, we will provide you with a special statement of services for use when you submit your claim.

<CONTINUED>

YES NO Are you currently wearing dentures? If yes, when did you receive your last dentures?_____

YES NO Do you use denture adhesives, paste or powder? If so, please describe_____

HAVE YOU EVER HAD...

YES NO Teeth extracted? If so, when:_____

Any problems?_____

YES NO Bleeding problems?

YES NO Bad reaction to anesthesia (Novocaine?)

YES NO Allergic reaction to medications? (Penicillin or Codeine)

Please circle and/or specify:_____

YES NO Allergic reaction to latex? Please specify: _____

YES NO A heart attack or heart problems?

Please specify: _____ If so, when:_____

YES NO Prosthetic (false) joints, knee, hip, or valves?

Please specify. _____

YES NO Circulatory problems?

YES NO Tuberculosis or other chronic ailments? For example Chronic Obstructive Pulmonary Disease or C.O.P.D.

Please specify: _____

YES NO Hepatitis or liver disease?

YES NO Diabetes or kidney failure?

YES NO Rheumatic fever or heart murmur?

YES NO A stroke? If so, when:_____

YES NO High or low blood pressure? Please circle and/or specify: _____

YES NO Cancer? Where? _____ Radiation?_____ Chemotherapy?_____

YES NO Immune system disorder or infection including HIV?

YES NO Fainting spells or seizures?

YES NO Do you take ASPIRIN daily?

YES NO Are you taking birth control pills or using other hormonal birth control method

(For example, Norplant)? Please specify:_____

YES NO Are you taking, or have you ever taken prescription medication for osteoporosis (bone loss)?

(For example, FOSAMAX)? Please specify:_____

YES NO Are you pregnant or nursing?

YES NO Do you smoke or use tobacco products?

YES NO Do you use illegal drugs (For example marijuana or cocaine)?

YES NO Do you have any sores in your mouth?

Please list any medicines you currently take _____

(including Herbal Supplements): _____

Other Comments: _____

To the best of my knowledge the above questions have been answered accurately. I understand that the fee for dentures, extractions, and other services must be paid on the first visit after you are seen by the dentist.

PATIENT SIGNATURE:_____ Date:_____

Patient Name: _____

OUR PAYMENT POLICY

We gladly accept payment by cash, MasterCard, Visa and Discover. Some offices are able to accept checks with identification. You will need to check with the office you are visiting to confirm their payment policies.

Augusta Dental Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature *Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Relationship_____ Name _____

Relationship_____ Name _____

Relationship_____ Name _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

Employee signature Date