HAID DENTAL

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home # Cell#

P.O. box: City: State: ZIP Code:

Email: Employer: Employer phone no.: ( )

Who referred you to our office?

Other family members seen here: Previous Dentist:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Insurance Company Name and Address:

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: I.D. #: Co-payment:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: I.D. #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

AUTHORIZATION

I authorize the release of any information regarding dental history or treatment to the authorized agent for the purpose of determining benefits payable or for the direct payment of Tara L. Haid, D.D.S. for services completed. I Understand that the responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

Signature: _____ **Date:** _____

I acknowledge I have read and agree to all conditions of this agreement

HAID DENTAL

PATIENT MEDICAL HISTORY

Sex:	If female please answer the following :	Yes	No
	Are you taking birth control pills?	☐	☐
	Are you pregnant?	☐	☐
	Are you Nursing?	☐	☐

Do You smoke or use tobacco Or use a Vape?	**ALLERGIES**	**MEDICATIONS:**
Y N	**Y N**	
☐ ☐	☐ ☐ Aspirin	
	☐ ☐ Codeine	
	☐ ☐ Dental Anesthetics	
	☐ ☐ Erythromycin	
	☐ ☐ Jewelry, Metals	
	☐ ☐ Penicillin	
	☐ ☐ Tetracycline	
	Other: _____	

Weight:	Height:	**Physician :**	**Physician phone:**

CONDITIONS

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Hemophilia
☐	☐	Acid Reflx	☐	☐	Hepatitis A Or B
☐	☐	Alcohol or Drug Abuse	☐	☐	High Blood Pressure
☐	☐	Allergies, Hay Fever	☐	☐	High Cholesterol
☐	☐	Anemia, Blood Disorders	☐	☐	Hypoglycemia
☐	☐	Angina Pectoris (chest pain)	☐	☐	Hypertension
☐	☐	Atrial fibrillation	☐	☐	Hospitalized in the last 5yrs., for? _____
☐	☐	Arthritis	☐	☐	Irregular Heart Beat
☐	☐	Artificial Joints, When? _____	☐	☐	Irritable Bowel Syndrome
☐	☐	Asthma	☐	☐	Kidney Problems
☐	☐	Blood Transfusion, When? _____	☐	☐	Liver Disease
☐	☐	Cancer, Type_____When? _____	☐	☐	Low Blood Pressure
☐	☐	Chemotherapy, When?_____	☐	☐	Mitral Valve Prolapse, With Regurgitation ? _____
☐	☐	Cardiovascular Disease	☐	☐	Multiplesclerosis
☐	☐	Celiac Disease	☐	☐	Muscular Dystrophy
☐	☐	Chronic Fatigue	☐	☐	Narcolepsy
☐	☐	Chronic Pain	☐	☐	Neuralgia
☐	☐	Congenital Heart defects	☐	☐	Osteoarthritis
☐	☐	COPD	☐	☐	Pace Maker
☐	☐	Diabetes: Type I or II	☐	☐	Pancreatitis
☐	☐	Difficulty Breathing	☐	☐	Parkinson's disease
☐	☐	Emphysema	☐	☐	Psychiatric Problems
☐	☐	Fainting Spells	☐	☐	Radiation Therapy, When? _____
☐	☐	Fever Blisters	☐	☐	Rheumatic Fever/Heart Disease
☐	☐	Fibromyalgia	☐	☐	Rheumatoid Arthritis
☐	☐	Frequent Headaches	☐	☐	Seizures, Epilepsy
☐	☐	Glaucoma	☐	☐	Shingles
☐	☐	HIV or AIDS	☐	☐	Sickle Cell Disease
☐	☐	Heart Attack, When?_____	☐	☐	Sinus Problems
☐	☐	Heart Surgery, When?_____	☐	☐	Sleep apnea, do you wear an oral appliance or CPAP?
☐	☐	Heart Valve Replacement, When?	☐	☐	Snoring
			☐	☐	Sores lasting more than 1 week
			☐	☐	Stroke

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☐ ☐	Tuberculosis, Lung Ailments	**Dental History**	
☐ ☐	Ulcers	**Y N**	
☐ ☐	Venereal Disease	☐ ☐	Have you ever been treated for periodontal disease? When?_____
☐ ☐	Yellow Jaundice	☐ ☐	Have you ever had orthodontics? When? _____
☐ ☐	Thyroid problems	☐ ☐	Do you have Dental Anxiety?
☐ ☐	Other Conditions	☐ ☐	Do you Floss? How often? _____
		☐ ☐	Do your gums bleed when you brush and floss?
		☐ ☐	Have you ever been told or notice that you grind your teeth?
		☐ ☐	Do you have a Nightguard?____ do you wear it?_____
			When was your Last cleaning and examination? _____

SIGNATURE: _____DATE_____
If under 18 Parent or Guardian Signature Required

I acknowledge I have read and agree to all conditions of this agreement

HAID DENTAL

I understand that, under the Health Insurance Portability &Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Name of Authorized Party if Not Patient: _____

Signature: _____ **Date**_____

I acknowledge I have read and agree to all conditions of this agreement