PATIENT HEALTH RECORD

Date____________________

Name____ Spouse's Name____________________________
(Last) (First) (Initial)

Address____

City_________________________________ State________________ Zip Code____________________

Business Name____

Home Phone______________________________ Business Phone______________________________

Cell Phone_______________________________ E-mail Address______________________________

Date of Birth_____________________________ Sex________ Height___________ Weight_________

Occupation___________________________ Social Security No._____-_____-_____ Single_____ Married_____

Closest Relative__________________________________ Phone#___________ Cell#_______________

Whom may we thank for referring you to us?____

MEDICAL HEALTH

Name and address of physician____

Have you been under a physician's care during the past 2 years?_______ For__________________________

Have you been treated in a hospital in the past 2 years?______ For_______________________________

Have you ever had major surgery?____

If female: Are you taking hormones or birth control?___________ Are you pregnant or nursing?___________

Have you ever been exposed to hepatitis?___________________ Were you vaccinated?________________

Have you ever had cankers or cold sores on your lips, tongue, gums, or body?_________________________

Are you now taking or have you taken any prescription medications within the past year? Please list. ________

____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Latex ☐ Other (please list)

____

Have you had or do you now have:

	yes	no		yes	no
Abnormal blood pressure	☐	☐	Hepatitis	☐	☐
AIDS	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Jaundice	☐	☐
Anemia	☐	☐	Kidney disease	☐	☐
Angina	☐	☐	Liver disease	☐	☐
Arthritis	☐	☐	Organ transplant	☐	☐
Artificial heart valves	☐	☐	Pacemaker	☐	☐
Artificial joints	☐	☐	Polio	☐	☐
Asthma	☐	☐	Prolonged bleeding	☐	☐
Cancer	☐	☐	Prolonged cough	☐	☐
Chemotherapy	☐	☐	Psychiatric treatment	☐	☐
Congenital heart lesions	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle cell anemia	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Ulcers	☐	☐
Heart murmur	☐	☐	Venereal disease	☐	☐

Have you had any disease, condition, or problem not previously listed?____________________________

____

DENTAL HEALTH

When was your last dental visit? ______

How often did you see your dentist? ______

Are you having any dental problems that require immediate attention? ______

Do any of the following cause tooth discomfort? Hot ____ Cold ____ Sweets ____ Chewing ______

How often do you brush your teeth? ______ Floss? ______ Water jet? ______

Do your gums bleed while cleaning? ______

Do your gums ever feel tender or swollen? ______

Have you ever had periodontal treatment? ______ When? ______

Do you clench or grind your teeth? ______

Do your jaws ever feel tired or ache? ______ Click or pop? ______

Can you chew on both sides of your mouth? ______ Comfortably? ______

Do you have frequent headaches? ______ Earaches? ______

Have you ever had orthodontic treatment (braces)? ______ When? ______

Do you lose fillings or break fillings? ______

Do you usually have many cavities? ______

Do you have any loose teeth? ______ Cracked or broken teeth? ______

Do you have any noticeable wear on your teeth? ______ Food traps? ______

Do you have any missing teeth? ______ Have they been replaced? ______
If so, how? Fixed bridge ______ Removable partial ______ Full Denture ______ Dental implant ______

Are you comfortable with the replacement? ______ Please describe ______

______

How do you feel about the appearance of your smile? ______

Have you ever had any cosmetic dentistry done to improve your appearance? ______

If yes, are you pleased with the result? ______ Please comment ______

______

Have you ever had an unpleasant dental experience? ______

AUTHORIZATION FOR TREATMENT

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those anesthetics or premedications which may be deemed advisable by the doctor. I will be responsible for any financial obligation for treatment on myself or the above named child.

Signature ______ Date ______

Trent's Prints (850) 994-1421 Form 1317

Woodbine Family Dentistry

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of **Woodbine Family Dentistry**. I hereby authorize, as indicated by my signature below, **Woodbine Family Dentistry** to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

______________________________ ______________________________
Print Name Address

______________________________ ______________________________
Signature Date

Please check your preferred means of communication:

- □ You may contact me at my home telephone number: ____________________
- □ You may contact me on my mobile telephone number: ____________________
- □ You may contact me on my work telephone number: ____________________
- □ You may send me an email at: ____________________
- □ Other: ____________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. ____________________ Relationship: __________ Date __/__/__ added/removed

2. ____________________ Relationship: __________ Date __/__/__ added/removed

3. ____________________ Relationship: __________ Date __/__/__ added/removed

****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 the acknowledgement
- □ Other (Please Specify): ____________________

Staff Person Initials: ________

Woodbine Family Dentistry

Reid Hines, D.M.D.   Alan McGinnis D.M.D.

Patient Information: This section refers to the PATIENT ONLY

First Name: ______________________ Jr., II, ____

Last Name: ______________________ MI _____

Nickname / Alias: ______________________

Address: ______________________

City: ____________ State: ____ Zip: ________

Home Phone: ( ) ______________________

Work Phone: ( ) ____________ Ext ______

Cell Phone: ( ) ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date (mm/dd/yy): ________ Sex: ☐ Male ☐ Female

Social Security Number: ______________________

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

If employed, Company: ______________________

____

Occupation: ______________________

Address: ______________________

____

City/State: ______________________

Zip: ____________

If Student ☐ Full-time ☐ Part-time

Name of School: ______________________

____

Responsible Party: If Patient is a minor

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Employer ☐ Other: ______

First Name: ______________________ Jr., II, ____

Last Name: ______________________ MI _____

Nickname / Alias: ______________________

Address: ______________________

City: ____________ State: ____ Zip: ________

Home Phone: ( ) ______________________

Work Phone: ( ) ____________ Ext ______

Cell Phone: ( ) ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date (mm/dd/yy): ________ Sex: ☐ Male ☐ Female

Social Security Number: ______________________

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

If employed, Company: ______________________

____

Occupation: ______________________

Address: ______________________

____

City/State: ______________________

Zip: ____________

APPOINTMENTS

WE ASK THAT WITH ANY CANCELLATION WE ARE NOTIFIED AT LEAST 24 HOURS IN ADVANCE. TWO (2) MISSED APPOINTMENTS WITHOUT THE 24 HOUR NOTICE, WILL RESULT IN A FEE OF $50, AND NO NEW APPOINTMENTS WILL BE MADE UNTIL THE FEE HAS BEEN PAID.

AN EMERGENCY FEE WILL BE ADDED TO AFTER HOURS VISITS.

DATE ____________ SIGNATURE ______________________

PATIENT/PARENT OR GUARDIAN

Subscriber Information: This section refers to the PATIENT IN WHOSE NAME THE INSURANCE IS FILED

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: ____________

First Name: ______________________ Jr., II, ____
Last Name: ______________________ MI _____
Address: ______________________________
City: ______________ State: _____ Zip: ________
Home Phone: (______) ______________________
Work Phone: (______) ______________ Ext ______
Cell Phone: (______) ______________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Birth Date (mm/dd/yy): ________ Sex: ☐ Male ☐ Female
Social Security Number: ____________________
Race: ☐ African American ☐ American Indian ☐ Asian
☐ Caucasian ☐ Hispanic

If employed, Company: ____________________
Insurance Co Name: ____________________
Insurance Phone #: ____________________
ID/Subscriber/Memb # ____________________
Group# ____________________

Subscriber Information: This section refers to the PATIENT IN WHOSE NAME THE INSURANCE IS FILED

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: ____________

First Name: ______________________ Jr., II, ____
Last Name: ______________________ MI _____
Address: ______________________________
City: ______________ State: _____ Zip: ________
Home Phone: (______) ______________________
Work Phone: (______) ______________ Ext ______
Cell Phone: (______) ______________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Birth Date (mm/dd/yy): ________ Sex: ☐ Male ☐ Female
Social Security Number: ____________________
Race: ☐ African American ☐ American Indian ☐ Asian
☐ Caucasian ☐ Hispanic

If employed, Company: ____________________
Insurance Co Name: ____________________
Insurance Phone #: ____________________
ID/Subscriber/Memb # ____________________
Group# ____________________

Office Payment Policy

I understand and agree that Dental and accidental policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Dental Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Dental Office will be credited to my account on receipt.
However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
Any unpaid balance over 90 days may be subject to a late fee.

Patient's Signature ______________________________ Date: ____________________

Parent or Guardian's Signature: ______________________________

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of **Woodbine Family Dentistry** to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

______________________________ ______________________________
Date Signature of Patient and/or Guardian, if patient is Minor