ADVANCED DENTAL

ESTABLISHED 2000

803 S. Jefferson Ave. Lebanon, MO 65536
417-588-2555 or 866-588-2555

I, _____, hereby authorize release of my Protected Health Information for discussion of my
Please Print Patient's Name
care, treatment or payment to the person(s) specified below (45CFR, 164.502(F) & 164.502(G).

Authorized family member or person to receive information for the above named patient's care or payment.

***Print** Primary Contact* (other than patient)	*Relationship to Patient*	*Phone #*

Others authorized to receive my information (please list names and relationships)

***Print** Name*	*Relationship to Patient*	*Phone #*
***Print** Name*	*Relationship to Patient*	*Phone #*
***Print** Name*	*Relationship to Patient*	*Phone #*

*Note: This form does not give the above referenced persons permission to make health care decisions for the patient. We will not release via the phone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is discussed.

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*May we leave messages on an answering machine? Yes No
(Example: Appointment reminders, scheduling changes or follow up after treatment calls.?)

*May we leave message for patients to return call? Yes No
(Example: May we leave a message regarding appointment reminders, scheduling changes or follow up calls)

- Acknowledgement Statement :

I have been offered a copy of the Notice of Privacy Practices and *received* a copy __
Please Check One
I have been offered a copy of the Notice of Privacy Practices and *declined* a copy __

Patient_____ SS#_____ Date _____
(*Signature*)

Personal Representative_____ Relationship to patient_____
Name of person other than pt. completing form) ***Please Print***

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Eff Date

Waiting periods

Waiting periods

Care Credit

VA

Phone #

Travel

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

*Advanced Dental Medical History

Patient Name: (7429) Assistants 2 (<<<2 ... Birth Date: 1/1/2000 Date Created: 2/17/2017

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you been under a physician's care in the last 12 months?	Yes No	If yes
Have you ever been hospitalized or had a major operation in the last 5 years?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs? Please list below.	Yes No	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

WOMEN ONLY:

Pregnant/Trying to get pregnant? If yes, how many months.	Yes No	If yes
Nursing?	Yes No	
Taking oral contraceptives?	Yes No	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Do you have additional Allergies not listed? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No	Anemia	Yes No
Angina	Yes No	Arthritis/Gout	Yes No	Artifical Heart Valve	Yes No	Asthma	Yes No
Blood Disease	Yes No	Blood Transfusion	Yes No	Breathing Problems	Yes No	Bruise Easily	Yes No
Cancer	Yes No	Chemotherapy	Yes No	Chest Pains	Yes No	Cold Sores/Fever Blisters	Yes No
Congenital Heart Disorder	Yes No	Cortisone Medicine	Yes No	Diabetes	Yes No	Drug Addiction	Yes No
Emphysema	Yes No	Epilepsy or Seizures	Yes No	Excessive Bleeding	Yes No	Fainting Spells/Dizziness	Yes No
Frequent Headaches	Yes No	Genital Herpes	Yes No	Heart Murmur	Yes No	Heart Pacemaker	Yes No
Hemophilia	Yes No	Hepatitis A	Yes No	Hepatitis B or C	Yes No	Herpes	Yes No
High Blood Pressure	Yes No	High Cholesterol	Yes No	Hypoglycemia	Yes No	Irregular Heartbeat	Yes No
Kidney Problems	Yes No	Leukemia	Yes No	Liver Disease	Yes No	Low Blood Pressure	Yes No
Lung Disease	Yes No	Mitral Valve Prolapse	Yes No	Osteoporosis	Yes No	Parathyroid Disease	Yes No
Psychiatric Care	Yes No	Radiation Treatments	Yes No	Renal Dialysis	Yes No	Rheumatic Fever	Yes No
Shingles	Yes No	Sickle Cell Disease	Yes No	Sinus Trouble	Yes No	Stomach/Intestinal Disease	Yes No
Stroke	Yes No	Swelling of Limbs	Yes No	Thyroid Disease	Yes No	Tuberculosis	Yes No
Tumors or Growths	Yes No	Ulcers	Yes No	Venereal Disease	Yes No		

Have you ever had any illness not listed above? Yes No If yes

Artifical Joint and Heart Information:

Do you have an artifical joint? If yes, please list the doctor and date of placement.	Yes No	If yes
Have you ever had a heart attack? If yes, please list the doctor and date.	Yes No	If yes
Have you had a heart stent placed? If yes, please list the doctor and date of placement.	Yes No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____