Medical History:

Patient Name: _____ Date of birth: _____

Please Check YES or NO

Condition	YES	NO	Condition	YES	NO
Chemical Dependency			Cancer		
Diabetes			Thyroid Disorder		
Stroke			Back Problems		
High Blood Pressure			Sleep Apnea		
Headaches			AIDS/HIV		
Anemia			Herpes		
Asthma			Sinus Trouble		
Pacemaker			Rheumatic Fever		
Artificial Heart Valves			Glaucoma		
Artificial Joints			Hepatitis A B C		
Seizures			Bleeding Disorders		
Liver Disease			Depression		
Kidney Disease			Tuberculosis		
Radiation Treatment			Jaw Pain		

Please explain any conditions that were marked **YES**, if necessary:

_____

_____

_____

Are you required to PREMEDICATE before dental and medical procedures? **YES** ☐ **NO** ☐

New Patient Information Form

Personal Information:

Full Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Dental Insurance Information:

Checkmark the box if you have no dental insurance (Self-Pay) ☐

Insurance Company Name: _____ **Member ID**: _____

Subscriber Name (if different): _____ Subscriber Date of Birth: _____

Subscriber Employer: _____ Secondary Insurance?: **YES** **NO**

Social Security Number: _____ Group Number: _____

Medical Information:

Physician Name: _____ Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Cross Streets: _____

MEDICATIONS	**ALLERGIES**

Are you **pregnant** or **nursing**? If yes, please specify: _____

Are you currently taking Birth Control? YES ☐ NO ☐

Dental Health History:

Date of last dental visit: _____ Date of last dental cleaning: _____

Reason for your visit today: _____

_____

Consent and Authorization:

I authorize the release of any information necessary to process insurance claims. I consent to dental treatment as recommended by the dentist. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Print Name: _____ Date: _____

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOURSELF MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Affordable Dental Care is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices that is described in the notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

You have the right to review our privacy practices, the right to access any health information or amendments made to it. You also have the right to an accounting of disclosures and restrict uses of communicating health information.

We may use and disclose health information about your treatment, payment, and healthcare operations (which does include communication with your general dentist or physician).

We will not use your health information for any manner of direct or indirect personal gain or other unauthorized use. We may use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or a possible victim of other crimes.

We will not use or dispose of your health information for any reason other than those listed without your written authorization.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. For more information about our privacy practices, please contact our office manager at (480) 354-6177.

I have read and understand the privacy practices of Affordable Dental Care. I consent to Affordable Dental Care to disclose my protected health information as described.

In addition to our use of our health information for treatment, payment, or healthcare options, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

_____I authorize the use of my health information for any other purpose other than what is stated in the Notice of Privacy Practices.

_____I do not authorize the use of my protected health information for any other purpose other than what is stated in the Notice of Privacy Practices.

X_____ _____

Signature of Patient or Guardian Date