Luminous Smiles

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Patient Information

Patient Name: _____

Gender: Male____ Female____

Family Status: Married____ Single____ Child____ Other_____

Birth Date: _____ Social Security # _____

Email Address: _____

Home # _____ Mobile # _____

Work # _____ Ext. _____

Address: _____

City, State, Zip Code _____

In case of an emergency, who should be notified? Also include their relationship to you.

Name:_____

Telephone #:_____

Medical History

Physician's Name: _____ Phone # _____

Pharmacy Name: _____ Phone # _____

Please put an X if you have any **allergies** to the following:

Aspirin ____ Erythromycin ____ Sulfa ____ Penicillin ____

Tetracycline ____ Codeine ____ Ciprofloxacin _____ Keflex _____ Dental Anesthetics ____

Jewelry ____ Latex ____

Other: _____

Have you had any serious illnesses or operations? _____

If yes, describe

_____

_____

Do you need to take premedication before dental work? _____

FEMALES ONLY:

Women: Are you pregnant? _____ Nursing? _____

Taking birth control pills _____

Please list any medications, vitamins, or supplements that you are currently taking:

_____

_____

_____

Indicate which of the following conditions you have or have had. By putting an X on the line in front of the condition listed, you are indicating a "Yes" response. By leaving the line blank, it will indicate a "No" response.

__ Pre-med Amoxicillin
__ Pre-med Clindamycin
__ Pre-med Other
__ Abnormal Bleeding
__ Alcohol Abuse
__ Allergies
__ Anemia
__ Angina Pectoris
__ Arthritis
__ Artificial Bones
__ Artificial Heart valve
__ Asthma
__ Blood Disease
__ Cancer-Chemo
__ Congenital Heart
__ Contrast Dye
__ Cosmetic Surgery
__ Diabetes
__ Difficulty Breathing
__ Emphysema
__ Epilepsy
__ Fainting Spells
__ Fever Blisters
__ Glaucoma
__ Hay Fever
__ Heart Attack
__ Heart Surgery
__ Hemophilia
__ Hepatitis B
__ High Blood Pressure
__ HIV + Aids
__ Kidney Problems
__ Liver Disease
__ Low Blood Pressure
__ Mitral Valve
__ Other
__ Radiation Therapy
__ Rheumatic Fever
__ Seizures
__ Shingles
__ Sinus Problems
__ Stroke
__ Thyroid Problems
__ Ulcers
__ Use Tobacco
__ Venereal Disease
__ Yellow Jaundice

Person Responsible for Account & Insurance

Person responsible for Account:_____

Relation to Patient:_____ Birthdate:_____SS#:_____

Address:_____ Phone#:_____

City:_____ State:_____ Zip:_____

Person Responsible Employed by:_____

Insurance Company:_____

Subscriber ID# _____ Group#:_____

Is patient covered by additional insurance Yes____ No____

Additional Insurance Plan:_____

Subscriber ID#:_____ Group#:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date