HI-TECH DENTISTRY, P.C. WATERFORD, MI 48327

PATIENT INFORMATION

(HIPPA COMPLIANT/ CONFIDENTIAL)

Patient Name _____Birthdate_____

Responsible Party_____Birthdate_____

Address_____
(street) *(city)* *(zip code)*

Home Phone_____Business Phone_____

Cell Phone_____Email Address_____

How would you prefer to be contacted?_____

Employer_____Dental Ins. Carrier_____

Social Security #_____Ins. ID #_____

Spouse Name_____Birthdate_____

Spouse Employer_____Ins. Carrier_____SS#_____

Physician Name_____Phone Number_____

Emergency contact person name_____Phone#_____

Purpose of this visit_____

Date of your last dental visit_____Any specific concerns about dental care?_____

Who may we thank for referring you?_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Hi-Tech Dentistry to provide my insurance company(s), claims administrators(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I also authorize payment of all dental benefits directly to Hi-Tech Dentistry, P.C.

I understand I will be responsible for any and all charges not covered by my dental insurance plan.

( ) ( )

(responsible party signature) ***(today's date)***

** * PLEASE COMPLETE REVERSE SIDE ***

HEALTH HISTORY

Are you currently under a physician's care? If yes, what are you being treated for?_____

Please list all medications you are currently taking along with the condition and dosage_____

Any serious illness, or general health problem we should be aware of?_____

(Women) Are you pregnant?_____Do you take oral contraceptives?_____

Do you smoke? (cigarettes)_____(cigars)_____(pipe)_____(chew snuff or tobacco)_____per day_____

Have you ever been advised to take antibiotics prior to dental treatment?_____

Have you ever had or been treated for:			**Are you allergic to:**		
Heart Disease or Rheumatic Fever	Yes	No	Penicillin	Yes	No
Heart Murmur, Mitral-Valve Prolapse	Yes	No	Erythromycin	Yes	No
High Blood Pressure or Stroke	Yes	No	Tetracycline	Yes	No
Diabetes	Yes	No	Codeine	Yes	No
Hepatitis,Blood Disorder, Anemia	Yes	No	Aspirin	Yes	No
Tuberculosis, Lung Ailments	Yes	No	Sulfa	Yes	No
Epilepsy, Seizures, Fainting Spells	Yes	No	Iodine	Yes	No
Thyroid Problems	Yes	No	Latex	Yes	No
Cancer, Radiation Treatment	Yes	No	Anesthetics	Yes	No
Kidney Disease, Dialysis, Transplants	Yes	No	Miscellaneous Allergies		
Orthopedic Joint Replacement	Yes	No	_____		
Ulcers, Intestinal Problems	Yes	No	_____		
Asthma, hay fever, hives	Yes	No	_____		
HIV Positive, AIDS	Yes	No	_____		
Psychiatric, Emotional Care	Yes	No	_____		

Signature_____Date_____

FOR INTER-OFFICE USE ONLY

Date_____Changes Noted_____Initials_____
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