Family Dental Care

5386 State Road
Parma, OH 44134

Date: _____/_____/_____

Patient Information

Name: _____
Date of birth: _____
Social security #: _____
Address: _____
City/State/ Zip: _____
Home #: _____Cell # _____
Email: _____

_____ Single _____ Married
_____ Divorced _____ Widowed

Name of person responsible for account:

Name:_____
Social security # _____
Date of birth: _____
Name of Employer: _____
Employer address: _____
Business Phone #: _____
Occupation: _____
Driver License/Sate ID #: _____
Do you have Insurance? Yes / No
Insurance Company name: _____
Member #: _____
Name of Spouse: _____
Social security # _____
Date of birth: _____
Name of Employer: _____
Employer address: _____
Business Phone #: _____
Occupation: _____
Driver License/ State ID #: _____
Secondary Insurance? Yes / No
Group #: _____
Secondary Ins. Name: _____
Name of nearest relative: _____
Cell Phone #_____
Address: _____
Whom may we thank for referring you?
Name: _____Phone# : _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage. *****INTEREST IS CHARGED ON UNPAID BALANCES***

Medical History

Physician's Name: _____
Last Visit: _____
Are you pregnant? Yes / No
Taking Birth control pills? Yes / No
Do you take Pre-Meds? Yes/No

Please **Circle** if you have or had any of the following:
AIDS/HIV Anemia Asthma Anxiety Arthritis
Back Problems Blood Diseases
Cancer Chemical Dependency
Chemotherapy/Radiation Tx. Cough up blood
Diabetic-Type-1 Diabetic-Type-2 Epilepsy Fainting
Heart problems please describe:
_____
_____
High/Low blood pressure Hepatitis A/ B / C
Jaw pain Kidney Disease Liver Disease
Glaucoma Nervous Problems Pacemaker
Psychiatric Care Respiratory Disease
Rheumatic Fever Scarlet Fever Skin Rash
Stroke Swelling of Feet or Ankles
Thyroid Problems Tonsillitis Tuberculosis
Headaches Joint Replacements (SEE LIST) (NONE)

Medications

You are currently taking:
_____
_____
_____
_____**(NONE)**

Any Surgeries? _____
_____
_____**(NONE)**

Allergies

Aspirin Barbiturates Codeine Penicillin Sulfa
Other: _____

_____**(NONE)**

Patient/Parent/Guardian Signature:

X_____

Printed Name:_____

BACK SIDE---------->

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PRIVACY PRACTICES: Medical and Dental Information Release

Form (HIPAA)

Patient Name: _____D.O.B_____/_____/_____

SSN: _____-_____-_____

Release of Information

(Please check appropriate boxes)

[ ] By checking this box I authorize the release of medical and dental information including diagnosis, treatment plans and records, x-rays, prescription history, payment history, account balances, and insurance status and claim information. This information may be released to any required dental/medical insurance provider, legal entity, and medical or dental professional outside of this office (e.g., professional referrals and medical clearance).

[ ] I grant Family Dental Care permission to disclose my identity and information to anyone who may answer my HOME, WORK, or CELL PHONE.

[ ] I grant Family Dental Care permission to LEAVE A MESSAGE to any person or voicemail/answering service who may answer my HOME, WORK, or CELL PHONE.

I also authorize release to (please provide full name):

[ ] Spouse_____
[ ] Child(ren) _____
[ ] Other _____

[ ] Information is not to be released to anyone except necessary dental/medical insurance providers.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____Date: _____/_____/_____

Printed Name: _____