PATIENT INFORMATION FORM

PATIENT DETAILS

Patient's First Name: Bruce | Patient's Last Name: Wayne | Nickname: Dark Knight

Patient's Address: 1007 Mountain Drive | City: Gothem | State: UT | Zip: 84003

Interests/Sports/Hobbies: | Gender: Male | Home Phone: (801) 326-5987

Date of Birth: 04/07/1989 | Age: 30y 3m | Race: White | Cell Phone: (801) 326-5987

School/Employer: | Grade/Position: | Work Phone: (800) 232-6566

How did you hear about our office: co-worker | Patient's Email: darknight@batman.com

Family members treated in our office: Alfred

Reason for consultation: Tooth Ache

Dentist: Dr. Chase Meridian | Date of last cleaning:

Is the patient a minor ☐ Yes ☑ No

RESPONSIBLE PARTY / INSURANCE INFORMATION

☑ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify)

Guardian's First Name: Bruce | Guardian's Last Name: Wayne | Home Phone: (801) 326-5987

Address: 1007 Mountain Drive | City: Gothem | State: UT | Zip: 84003

Employer: School/Employer | Work Phone: (800) 232-6566

Date of Birth: 04/07/1989 | Social Security Number: 123-45-7899 | Cell Phone: (801) 326-5987

OTHER INSURANCE (IF APPLICABLE): | Guardian's E-Mail: darknight@batman.com

Company Name: | Phone: | Subscriber/Member ID:

RESPONSIBLEPARTY2 / INSURANCE INFORMATION

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify)

Guardian's First Name: | Guardian's Last Name: | Home Phone:

Address: | City: | State: | Zip:

Employer: | Work Phone:

Date of Birth: | Social Security Number: | Cell Phone:

OTHER INSURANCE (IF APPLICABLE): | Guardian's E-Mail:

Company Name: | Phone: | Subscriber/Member ID:

SLEEP / AIRWAY ISSUES

Does the patient tend to be a mouthbreather? ☐ Yes ☑ No

Does the patent seem rested in the morning? ☐ Yes ☑ No

Has the patient seen an Ear, Nose & Throat Specialist? ☐ Yes ☑ No

Does the patient snore at night? ☑ Yes ☐ No

Is the patient often sleepy during the day? ☑ Yes ☐ No

Is the patient using a sleep apnea device? ☑ Yes ☐ No

DENTAL/MEDICAL HISTORY

Please check if the patient has a history of the following medical conditions:

- [x] AIDS
- [ ] Alzheimer's/Dementia
- [ ] Anemia
- [x] Arthritis, Rheumatism
- [x] Artificial Heart Valves
- [ ] Artificial Joints/Joint Replacement
- [ ] Asthma
- [x] Back Problems
- [x] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependency
- [x] Chemotherapy
- [x] Circulatory Problems
- [ ] Cortisone Treatments
- [ ] Cough, Persistent
- [x] Cough up Blood
- [x] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [x] Glaucoma
- [x] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems, Describe: _____
- [x] Hemophilia
- [x] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV Positive
- [x] Jaw Pain
- [x] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [x] Mitral Valve Prolapse
- [x] Nervous Problems
- [ ] Pacemaker
- [ ] Psychiatric Care
- [x] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [x] Shortness of Breath
- [x] Sinus Infection
- [ ] Skin Rash
- [ ] Stroke
- [x] Swelling of Feet or Ankles
- [x] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tonsillitis
- [x] Tuberculosis
- [x] Ulcer
- [ ] Venereal Disease
- [ ] Vitamin B12 Deficiency

[x] Yes	[ ] No	Have you ever been treated for osteoporosis?	
[x] Yes	[ ] No	Are you or have you ever taken Bisphosphonates such as: Fosamax, Actonel, Boniva, Zometa or Aredia?	
[x] Yes	[ ] No	Have you ever taken Redux or Fen-Phen?	
[x] Yes	[ ] No	Do your gums bleed when you brush?	
[ ] Yes	[x] No	Is the patient seeing any other dental specialists (e.g., periodontist)?	
[x] Yes	[ ] No	Any dental restorations needing to be completed? What?	dental crowns
[ ] Yes	[x] No	Have there ever been any injuries to the face, mouth or chin?	
[ ] Yes	[x] No	Have you ever lost or chipped any teeth? Which tooth/teeth?	
[ ] Yes	[x] No	Do you have any pain or soreness around your face, neck or back?	
[ ] Yes	[x] No	Is any part of your mouth sensitive to temperature or pressure?	
[ ] Yes	[x] No	Is the patient currently pregnant? Due Date?	
[ ] Yes	[x] No	Have adenoids been removed? If yes, when?	
[ ] Yes	[x] No	Have tonsils been removed? If yes, when?	
[ ] Yes	[x] No	Currently taking any medications? List.	
[ ] Yes	[x] No	Are antibiotics necessary prior to treatment? List.	
[ ] Yes	[x] No	Allergies (i.e., Drug, Latex, etc.)	
[ ] Yes	[x] No	Any diseases or problems not mentioned above? List here.	

Please check if the patient has, or ever had, any of the following habits?

- [x] Cheek, tongue or lip chewing
- [x] **Clenching/grinding teeth**
- [ ] Finger nail biting
- [ ] **Thumb sucking**

SIGNED CONSENT

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an oral evaluation and consent to the taking of x-rays, photographs, and other records (if necessary) to determine appropriate treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Typed Name/Signature Bruce Wayne Relationship to Patient self Date 07/15/2019

If someone other than the parent(s) or guardian(s) listed above will be bringing the patient to appointments, please list here:
Alfred

HIPAA Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a HIPAA or the Healthcare Privacy Act). I understand that by signing this consent, I authorize This Office to use and/ or disclose my protected healthcare information to carry out the following:

- Treatment which includes direct and/ or indirect treatment by my other healthcare providers involved in my treatment.

- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/ companies.

- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses of disclosures of my protected health information, and my rights under HIPAA. I understand that your reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do not agree, you are bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Patient Name Bruce Wayne Date 07/15/2019