Welcome to True Dental Group

Patient Name____

How do you prefer to be addressed?______________________________

Mailing Address____

City_______________________ State_________ Zip ___________

Birth Date ____/______/_______ Age______ Sex: M F

Cell Phone (____)______-______ Home Phone (___)_______-___________

Driver License Number_______________ Social Security Number ______-_____-_____

Email Address____

Responsible Party Information (if different from patient)

Name___________________________ Relationship to patient_________________

Mailing Address____

City_______________________ State_________ Zip ___________

Birth Date ____/______/_______ Age______ Sex: M F

Cell Phone (____)______-______ Home Phone (___)_______-___________

Do you give permission to any other person to give consent for treatment: Yes or No
Who can consent for treatment__________________________________

Person to Contact in Case of Emergency

Name______________________________ Phone: (____)_______-_________

Acknowledgement of Receipt of Notice of Privacy Policy

you may refuse to sign this acknowledgement

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

_______________________ _______________________ ____________
Legal Name (Printed) Signature Date

Authorization to Release Information

I hereby authorize this facility to release my protected health information to:

Name ______________________ Phone Number ______________________

Name ______________________ Phone Number ______________________

Insurance Information

Dental Insurance: Primary Policy

Insurance name____

Address____

Policy Holder Name______________________ Relationship to Patient___________

Policy Holder Social Security Number______-____-_____ Member ID______________

Group Number__________________ Policy Holder Date of Birth _____/______/_____

Name of Employer______________ Employer Address________________________

Medical Insurance: Sometimes we can submit claims for dental procedures to your medical insurance to help maximize all of your benefits.

Insurance name____

Address____

Policy Holder Name______________________ Relationship to Patient___________

Policy Holder Social Security Number______-____-_____ Member ID______________

Group Number__________________ Policy Holder Date of Birth _____/______/_____

Name of Employer______________ Employer Address________________________

Medications/Drug Allergies

Please circle any medication listed below that you are allergic to, or have had a bad reaction to:

Aspirin	Iodine	Vicodin	Hydrocodone	Oxycodone
Codeine	Tylenol	Ibuprofen	Tramadol	Penicillin
Amoxicillin	Erythromoycin	Keflex	Z-Pack	Lidocaine
Tetracycline	Clydamycin	Sulfa	Nirtrous Oxide	Latex

Please list all medications you take on a regular basis: __________________________

____

Please list any medication you have taken in the last six months that you do not take on a regular basis:

____

Please circle the medical conditions that apply to you:

High Blood Pressure	Aids	Hemophilia
Diabetes	Alcoholism	Hepatitis
Heart Attack	Anemia	HIV
Stroke	Angina	Hives
Joint replacement	Asthma	Hyper Activity
Osteoporosis	Birth Control	Hypoglycemia
Congenital Heart Defect	Low blood pressure	Jaundice
Blood Thinners	Bruise Easy	Kidney Disease
Epilepsy/ Seizures	Deaf	Liver Disease
Drug Dependency	Drug Dependency	Mitral Valve Prolapse
Chronic Pain Therapy	Eating Disorder	Night Sweats
Cancer	Emphysema	Paralysis
Chemotherapy	Fainting Dizzy Spells	Psychiatric Treatment
Radiation Therapy	Cold Sores	Rheumatic fever
Obstructive Sleep Apnea	Gag Easy	Sickle Cell Disease
Cpap Machine	Glaucoma	Sinus Problems
Gerd/Acid Reflux	Headaches- frequent	STDs
ADHD	Hives	Tuberculosis

Please list any other serious illness or medical condition not listed above:

____

Jaw and Airway Assessment

Clicking of the jaw joints	Yes	No
Pain in or around the ears	Yes	No
Difficulty opening or closing the mouth	Yes	No
Difficulty chewing	Yes	No
History of trauma to the jaw	Yes	No
Do you snore loudly	Yes	No
Do you grind/clench your teeth	Yes	No
Do you feel tired or fatigued during the day	Yes	No
Have you ever been diagnosed with TMJ/TMD	Yes	No
Have you ever had your Airway Measured	Yes	No

How did you hear about our office?

____

Was our office easy to find? ____

Did you have any trouble finding a parking spot?

____