ELEVATE
dental wellness

·**Full Name:**_____

·**Preferred Name:**_____

·**Date of Birth:**_____

·**Male / Female:**_____

·**Email Address:**_____

·**Mailing Address:**_____

_____

·**Phone Number:** cell - _____

work - _____

home - _____

·**Preferred Method of Contact (circle preference):**

Email *Cell* *Home* *Work*

·**May we leave messages of a personal nature on your preferred method of contact?**

Yes *No*

·**How did you hear about us? - or - Whom may we thank for referring you?**_____

_____

·**Occupation:**_____

·**Employer:**_____

·**Employer's Address:**_____

_____

·**If a Student, Name of School:**_____

·**Emergency Contact Information:**_____

_____

·**SSN or DL / ID Number:**_____

·**Are you?:**

Minor *Single* *Married* *Domestic Partner*
Separated *Divorced* *Widowed*

·**Person Responsible for Payment on Account:**

(please complete if someone other than self):

*Name:*_____

*Relationship:*_____

*Date of Birth:*_____

*Mailing Address:*_____

_____

*Phone Number:*_____

*SSN or DL Number:*_____

·**Is this person currently a patient in our office?**

Yes *No*

·**Please fill out if you have dental insurance coverage:**

Insurance Company Name:_____

Insurance Company Address:_____

_____

Insurance Company Phone Number:_____

Group #:_____

INSURED'S Name:_____

INSURED'S relationship to YOU:_____

INSURED'S Date of Birth:_____

INSURED'S SSN or Member #:_____

INSURED'S Employer:_____

INSURED'S Employer's Address:_____

_____

·**Are you able to see an OUT OF NETWORK provider with your dental plan?**

Yes *No*

GENERAL MEDICAL QUESTIONS:

·Are you in good health at the present time?.....YES NO
·Are you currently under the care of a physician?.....YES NO

·Physician Name and Contact Number_____

·Have you been hospitalized or diagnosed with a serious illness in the past 5 years?.....YES NO
·Date of your last complete physical: _____

·Do you use or have you EVER used tobacco products (including electronic cigarettes)?.....YES NO
·If YES, what and how long?: _____

·*Women*: Are you currently taking oral contraceptives?.....YES NO
·Are you pregnant?.....YES NO
·If YES, how far along?:_____
·Are you planning a pregnancy in the near future?.....YES NO
·Are your nursing?.....YES NO
·Are you in menopause?.....YES NO

·Do you take vitamins and/or supplements?:.....YES NO
·If YES, please list type, dosage and frequency:_____
_____
_____

·Do you take prescribed medications?:.....YES NO
·If YES, please list type, dosage and frequency:_____
_____
_____

·Do you have food allergies?:.....YES NO
·If YES, please list:_____

·Please list *all* surgeries:_____
_____

ALLERGIES/ADVERSE REACTIONS: Do you or have you ever experienced an adverse reaction to the following?: YES or NO

Acetaminophen.....YES NO
Aspirin.....YES NO
Codeine.....YES NO
Dental Anesthetics.....YES NO
Erythromycin.....YES NO
Ibuprofen.....YES NO
Jewelry.....YES NO
Latex.....YES NO
Metals.....YES NO
Penicillin.....YES NO
Tetracycline.....YES NO
Sulfa.....YES NO
Other not listed_____

SPECIFIC MEDICAL HISTORY: Do you currently or have you ever had the following?: YES or NO

APO 3 / 4.....YES NO
Abnormal EKG.....YES NO
Abnormal Bleeding or Bruising.....YES NO
Alcohol / Drug Abuse.....YES NO
Allergies.....YES NO
Alzheimer's Disease or Family History of AD.....YES NO
Anemia / Leukemia.....YES NO
Angina Pectoris.....YES NO
Anticoagulant Therapy.....YES NO
Anxiety / Depression.....YES NO
Arthritis / Rheumatism.....YES NO
Artificial Heart Valve.....YES NO
Artificial Joints.....YES NO
Asthma .....YES NO
Autism Spectrum.....YES NO
Autoimmune Disease.....YES NO
B12 Deficiency.....YES NO
Back / Neck Problems.....YES NO
Bell's Palsy.....YES NO
Bronchitis.....YES NO
Cancer.....YES NO
Chemotherapy.....YES NO
Chest Pain.....YES NO
Chronic Ear Pain.....YES NO
Chronic Fatigue Syndrome.....YES NO
Cold Sores / Fever Blisters.....YES NO
Colitis.....YES NO
Concussion.....YES NO
Congenital Heart Defect.....YES NO
Delayed Healing from Infections.....YES NO
Diabetes or Familial History.....YES NO
Difficulty Breathing / COPD.....YES NO
Difficulty Swallowing / Lump in Throat.....YES NO
Dry Mouth.....YES NO
Eating Disorder.....YES NO
Emphysema.....YES NO
Emotional Disturbances.....YES NO
Epilepsy.....YES NO
Fainting Spells.....YES NO
Fibromyalgia.....YES NO
Frequent Fungal Infections.....YES NO
Frequent Headaches.....YES NO
Gastrointestinal Disorders.....YES NO
GERD.....YES NO
Glaucoma.....YES NO
Head Injury.....YES NO
Heartburn.....YES NO
HIV or AIDS.....YES NO
Heart Attack/Disease/Surgery or Familial History YES NO
Heart Murmur.....YES NO
Heavy Metal Toxicity.....YES NO
Hemophilia.....YES NO
Hepatitis A / B / C .....YES NO
Hormone Replacement Therapy (Men/Women)..YES NO
HPV (Men and Women).....YES NO
Hypertension / High Blood Pressure.....YES NO
Hypoglycemia.....YES NO
Immune Suppression.....YES NO
Infective Endocarditis.....YES NO
Insomnia.....YES NO
Kidney Problems.....YES NO
Liver Disease.....YES NO
Low Blood Pressure.....YES NO
Lupus.....YES NO
Mitral Valve Prolapse.....YES NO
MTHFR.....YES NO
Multiple Sclerosis.....YES NO
Oral Contraceptives.....YES NO
Osteoporosis.....YES NO
Pacemaker / Defibrillator.....YES NO
Persistent / Frequent Cough.....YES NO
Persistent / Frequent Throat Clearing.....YES NO
Persistent / Frequent Sore Throat.....YES NO
Premedication Required.....YES NO
Psychiatric Problems.....YES NO
Pulmonary Embolism.....YES NO
Radiation Therapy.....YES NO
Rapid Fatigue.....YES NO
Rheumatic Fever / Rheumatic Heart Disease.....YES NO
Ringing in the Ears / Tinnitus.....YES NO
Seizures.....YES NO
Shaky Hands / Feet.....YES NO
Shingles.....YES NO
Sickle Cell Disease.....YES NO
Sinus Problems.....YES NO
Snoring or Sleep Apnea.....YES NO
Stomach Ulcers.....YES NO
Stroke / TIA or Familial History.....YES NO
Swelling of Ankles / Feet / Hands.....YES NO
Swollen Lymph Nodes.....YES NO
Thyroid Problems.....YES NO
Tuberculosis.....YES NO
Tumors.....YES NO
Twitching of Muscles.....YES NO

Signature:_____ **Date:**_____

Elevate Dental Wellness

Privacy is important to us

Acknowledgement of Receipt of Notice of Privacy Practices, Financial & Rescheduling Policy and Informed Consent

I have received a copy of the Notice of Privacy Practices (HIPAA), Financial and Rescheduling Policy, and Informed Consent of **Elevate Dental Wellness**. I hereby authorize, as indicated by my signature below, **Elevate Dental Wellness** to use and disclose my protected health information for any necessary clinical, financial, or insurance purpose, as authorized in the Patient Consent Form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

o You may contact me at my home telephone number: _____
o You may contact me on my mobile telephone number: _____
o You may contact me on my work telephone number: _____
o You may send me an email at: _____
o Other: _____

Please list authorized persons with whom we may discuss your protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date___/___/___ added/removed
2. _____ Relationship: _____ Date___/___/___ added/removed
3. _____ Relationship: _____ Date___/___/___ added/removed

For office Use Only We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

o Individual refused to sign o Communication barriers prohibited obtaining the acknowledgement
o An emergency situation prevented us from obtaining the acknowledgement
o Other (Please Specify): _____

Staff Person Initials _____