LEGACY HILL DENTISTRY

Today's Date: _________

Patient's Full Name: ________________________________

Age: _____________________________

Address: ____

Birthday: _________________________

____

Social #: __________________________

____

Status: Married Single Child Other

Parent/Spouse's Name: ___________________________

Parent/Spouse Birthday: _____________

Email: ____

Parent/Spouse Social #: ______________

Patient's Home Phone #: __________________________

Cell Phone #: _______________________

Work Phone #: _____________________ **Ext #**: ______

Do you wish to receive text message reminders for your appointment? Yes No

How did you hear about our office? ____

Emergency Contact:

Name: ____

Phone # ______________________

Relationship: __________________________________

Who is responsible for this account? ____

Primary Ins Co: _____________________________

Subscriber: _________________________

Subscriber's Social: _________________________

Subscriber Birthday: __________________

Employer: ________________________________

Group #: ____________________________

Is patient cover by a secondary insurance company? Yes No

Secondary Ins Co: __________________________

Subscriber: __________________________

Subscriber's Social: ________________________

Subscriber Birthday: ___________________

Employer: _______________________________

Group #: ____________________________

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with __________________________ and assign directly to Legacy Hill Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Date: _________________

Relationship to patient: ____

Acknowledgement of receipt of Notice of Privacy Practices:

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

Signature: ____ **Date**: _____________

Please list all parties/persons we can share your treatment or personal information with:

____

Dental History:

Reason for today's visit: ____

Former Dentist: ______________________________________ **City/State**: ______________________________

Date of last dental visit: ________________________________ **Last Date of X-rays**: _______________________

Please answer the following:

Bad Breath	**Y or N**	**Orthodontic Treatment**	**Y or N**
Bleeding Gums	**Y or N**	**Pain around ear**	**Y or N**
Blisters on lips or mouth	**Y or N**	**Periodontal Treatment**	**Y or N**
Burning Tongue	**Y or N**	**Sensitivity**	**Y or N**
Chew on one side of mouth	**Y or N**	**Sores or growths in mouth**	**Y or N**
Grinding Teeth	**Y or N**	**Tobacco use**	**Y or N**
Jaw Pain	**Y or N**	**Clicking or popping jaw**	**Y or N**
Lip or cheek biting	**Y or N**	**Dry Mouth**	**Y or N**
Loose teeth/broken fillings	**Y or N**	**Fingernail biting**	**Y or N**
Mouth Breathing	**Y or N**	**Food collection between teeth**	**Y or N**
Mouth pain	**Y or N**		

How often do you floss? _______________ **How often do you brush**? _____________

Do you like your smile? **Y or N** **What would you change**? _______________

Please list any and all medications that you are currently taking:

____

____

____

Are you taking prescription medication for Osteoporosis? **Y or N**

If yes, what is the name of the medication?

____

Who is your current Physician? ____ **Phone #** ______________________

Healthy History:

AIDS/HIV	**Y or N**	**Epilepsy**	**Y or N**	**Radiation Treatment**	**Y or N**
Anemia	**Y or N**	**Fainting/Dizziness**	**Y or N**	**Respiratory Disease**	**Y or N**
Arthritis	**Y or N**	**Glaucoma**	**Y or N**	**Rheumatic Fever**	**Y or N**
Artificial Heart Valves	**Y or N**	**Headaches**	**Y or N**	**Scarlet Fever**	**Y or N**
Artificial Joints	**Y or N**	**Heart Murmur**	**Y or N**	**Shortness of Breath**	**Y or N**
Asthma	**Y or N**	**Heart Problems**	**Y or N**	**Sinus Trouble**	**Y or N**
Back Problems	**Y or N**	**Hepatitis Type ____**	**Y or N**	**Skin Rash**	**Y or N**
Abnormal Bleeding	**Y or N**	**Herpes**	**Y or N**	**Special Diet**	**Y or N**
Blood Disease	**Y or N**	**High Blood Pressure**	**Y or N**	**Sleep Apnea**	**Y or N**
Cancer	**Y or N**	**Jaundice**	**Y or N**	**Stroke**	**Y or N**
Chemical Dependency	**Y or N**	**Jaw Pain**	**Y or N**	**Swollen Feet/Ankles**	**Y or N**
Chemotherapy	**Y or N**	**Kidney Disease**	**Y or N**	**Swollen Neck Glands**	**Y or N**
Circulatory Problems	**Y or N**	**Liver Disease**	**Y or N**	**Thyroid Problems**	**Y or N**
COPD	**Y or N**	**Low Blood Pressure**	**Y or N**	**Tonsillitis**	**Y or N**
Congenital Heart Lesions	**Y or N**	**Lupus**	**Y or N**	**Tuberculosis**	**Y or N**
Cortisone Treatment	**Y or N**	**Mitral Valve Prolapse**	**Y or N**	**Tumor/Growth**	**Y or N**
Persistent/Bloody Cough	**Y or N**	**Nervous Problems**	**Y or N**	**Ulcer**	**Y or N**
Diabetes Type _____	**Y or N**	**Pacemaker**	**Y or N**	**Venereal Disease**	**Y or N**
Developmental Delays	**Y or N**	**Psychiatric Care**	**Y or N**	**Weight Loss**	**Y or N**
Emphysema	**Y or N**	**Other: ____**			

Women: Are you pregnant? Y or N If yes, Due Date: ___________________ OBGY: _______________________

Taking Birth Control Pills? Y or N **Are you nursing**? Y or N

Allergies:

Aspirin	**Y or N**	**Local Anesthetic**	**Y or N**	**Barbiturates**	**Y or N**
Codeine	**Y or N**	**Penicillin**	**Y or N**	**Sulfa**	**Y or N**
Iodine	**Y or N**	**Latex**	**Y or N**	**Other: ______________________**	

By signing below, I fully understand that Legacy Hill Dentistry has a no-show policy. Within a 24-month period your first no show/cancellation less than 48-hours prior will be a warning, and your second no show/cancellation less than 48 hours will be a charge starting at $50.00 for your missed appointment. This is per patient policy, NOT per family.

Signature: ____

All of the above information is true and accurate to the best of my knowledge.

Completed by: ____ **Date**: __________________