OnSite DentalDFW

Patient Information

Patient Name:_____ ☐ Male ☐ Female Birth Date:_____

Phone (Home):_____ (Cell):_____

Email:_____

Address:_____
Street Apt #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Home Health Provider

☐ Sr Living/Retirement Community ☐ Internet ☐ Facebook ☐ Advertisement ☐ Dental Screening

☐ Other_____ Name of person/office referring you:_____

Responsible Party Information

Name:_____ ☐ Male ☐ Female Birth Date:_____

Phone (Home):_____ (Cell):_____

Email:_____

Address:_____
Street Apt #

_____
City State Zip Code

Emergency Contact Information

Who should we contact in case of an emergency: _____

Relationship to patient:_____

Emergency Contact Phone #:_____

Patient's Physician's Name:_____

Physician Phone #: _____

MEDICAL HISTORY

RMH:
D:
ALERT: ☐ Yes ☐ No

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
If yes, for what?_____

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
If yes, please list:_____

Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
If yes, for what?_____

List all medications/supplements/treatments you are taking now?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Artificial Joints (Hip, knee, etc)	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Emphysema/Bronchitis	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Seasonal allergies/Hives	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Stents, Rods, Pins Ever Placed	☐ Yes ☐ No	Neurological Disorder	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Psychiatric/Psychological	☐ Yes ☐ No
Diabetes (Type: ____)	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Kidney disease/dialysis	☐ Yes ☐ No	Fainting/Dizzy Spells	☐ Yes ☐ No
Liver disease	☐ Yes ☐ No	Substance Abuse	☐ Yes ☐ No
Hepatitis (Type: ____)	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Bruise/bleed easily	☐ Yes ☐ No	AIDS/HIV Positive	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		

Do you or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
Please list:_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication. NOTE: By typing your name in the Signature line below, you are digitally signing.

Patient / Responsible Party Signature_____Date:_____

Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or assist with, aid in or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, other governmental or third party payors, or any organizations contracting with any of the above or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical or financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective immediately.

Patient/Responsible Party Signature_____Date_____

By typing your name in the Signature line above, you are digitally signing.