## PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

### PERSONAL

Name: ______________________________________________
Last First MI (Preferred)

Birthdate: __________ SS #: __________ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: __________ Wireless Phone: __________

Email: ______________________________________________

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) __ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

______________________________________________

(If someone referred you here, please enter their name so we can thank them.)

### ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: ______________________________________________

Address 2: ______________________________________________

City: __________ State: ______ Zip: __________

Home Phone: __________

### INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: __________________________ Subscriber ID #: __________

Insurance Company: __________________________ Phone: __________

Employer: __________ Group Name: __________ Group #: __________

Please present insurance card to receptionist.

### INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: __________________________ Subscriber ID #: __________

Insurance Company: __________________________ Phone: __________

Employer: __________ Group Name: __________ Group #: __________

## MEDICAL HISTORY

Last Name: ____________________ First Name: _____________________ Birthdate: ________________

Name of Medical Doctor: ________________________________ City/State: _______________________

Emergency contact: _______________________ Phone: _____________________ Relationship: ________

**List all medications that you are now taking:**

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________
9. ______________________________________
10. ______________________________________

**Are you allergic to any of the following?**

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ___ | ___ | Anesthetic | ___ | ___ | Iodine |
| ___ | ___ | Aspirin | ___ | ___ | Latex |
| ___ | ___ | Codeine | ___ | ___ | Penicillin |
| ___ | ___ | Ibuprofen | ___ | ___ | Sulfa |

Other allergies not listed above: ____________________________________________________________

**Do you have any of the following medical conditions?**

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ____ | ____ | Acid Reflux/Heartburn | ____ | ____ | HIV/AIDS |
| ____ | ____ | Anxiety/Depression | ____ | ____ | Heart Mummer/Attack |
| ____ | ____ | Arthritis | | | Date________________ |
| ____ | ____ | Artificial Heart Valve | ____ | ____ | Joint Replacement Date__________ |
| | | Date: ___________ | | | Which Joint________________ |
| ____ | ____ | Asthma | ____ | ____ | Kidney Disease |
| ____ | ____ | Bleeding Problems | ____ | ____ | Pregnancy/Nursing |
| ____ | ____ | Cancer Type:____________ | ____ | ____ | Psychiatric Treatment |
| | | Date:____________ | ____ | ____ | Rheumatic Fever |
| ____ | ____ | Colitis | ____ | ____ | Season Allergies/Sinus Trouble |
| ____ | ____ | Diabetes | ____ | ____ | Stroke Date:__________________ |
| ____ | ____ | Epilepsy/Seizures | ____ | ____ | Thyroid Problems |
| ____ | ____ | Glaucoma | ____ | ____ | Ulcers |
| ____ | ____ | High Blood Pressure | | | |

Other conditions not listed above: ____________________________________________________________

Tabaco use? (Smoke, Chew, vape, pouches) If so, what kind and how much?

______________________________________________

Reason for today's visit: ____________________________________________ Are you in pain? ____

Comments: ______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

SIGNATURE_______________________________________________________________________________

**New Patients:**

Do you have a panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ________________

Do you have Bitewing x-rays that are less than 2 years old? ________________________________

Name of former Dentist: ____________________________________________________

Date of last cleaning and exam: ______________________________________________

**DENTAL HISTORY**

Y N

____ ____ Bleeding/Sore Gums/Periodontal Disease

____ ____ Bad Breath/Bad Taste

____ ____ Burning Tongue or Lips

____ ____ Change in Bite

____ ____ Clenching/Grinding Teeth

____ ____ Clicking or Popping Jaw

____ ____ Dentures/Dental Appliance

____ ____ Dry Mouth

____ ____ Dental Anxiety

____ ____ Difficulty Opening/Closing Jaw

____ ____ Implants

____ ____ Food Impaction

____ ____ Loose Tooth/Teeth

____ ____ Mouth Guard

____ ____ Root Canal Treatment

____ ____ Sensitive: Biting

Cold/Hot

Sweets

____ ____ Snoring

____ ____ Wisdom Teeth

J. Craig Alexander, D.M.D., M.A.G.D.

# Acknowledgement of Receipt of Notice of Privacy Practices

**You May refuse to Sign This Acknowledgement

I, ______________________________ (Please Print Name), have received a copy of this office's Notice of Privacy Practices

______________________________
(Signature)

______________________________
(Date)

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other ( Please Specify)

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