



# WELCOME

## ***Personal Information***

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Wishes to be called \_\_\_\_\_  Male  Female  Single  Married

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

In the event of an emergency, whom should we contact? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us?

- Yelp  Facebook  Insurance Website  
 Brochure  Instagram  Family/Friend \_\_\_\_\_  
 Google  Other \_\_\_\_\_

## ***Dental Insurance Information***

Subscriber Name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Subscriber Birthdate \_\_\_\_\_ SSN/ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Employer Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Additional Dental Coverage?  Yes  No

# Health History

Patient Name \_\_\_\_\_ Name wishes to be called \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years..... Yes or No

If yes for what? \_\_\_\_\_

Primary Care Physician's name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Have you taken any medication or drugs in the past two years..... Yes or No

Are you taking any medication, drugs or pills now?..... Yes or No

If yes, please list name(s) and dosage(s) \_\_\_\_\_

Are you sensitive to latex? ..... Yes or No

Are you aware of having any **allergic** or adverse reaction to any medication or substance?..... Yes or No

If yes, please list: \_\_\_\_\_

Have you been a patient in the hospital during the past five years? ..... Yes or No

Are you happy with the appearance of your teeth? ..... Yes or No

Do you like the color of your teeth?..... Yes or No

Have you ever thought about whitening your teeth..... Yes or No

Have you ever thought of straightening your teeth with custom dental trays?..... Yes or No

Do you wake up feeling tired or with headaches?..... Yes or No

Are you currently taking any medications for osteoporosis or bone strength?..... Yes or No

Indicate which of the following you have had or have at present. (Please circle **YES** or **NO**)

Heart (Disease, Attack)	Y / N	Diabetes	Y / N	HIV/AIDS	Y / N
Chest Pain	Y / N	Thyroid Problems	Y / N	Hepatitis (A, B, or C)	Y / N
Artificial Heart Valve	Y / N	Emphysema	Y / N	Liver Disease	Y / N
Pacemaker	Y / N	Tuberculosis	Y / N	Kidney Trouble	Y / N
High Blood Pressure	Y / N	Asthma	Y / N	Epilepsy/Seizures	Y / N
Blood Thinners	Y / N	Cancer	Y / N	Fainting/Dizzy Spells	Y / N
History of Stroke	Y / N	Chemotherapy	Y / N	Nervous/Anxious	Y / N
Bruise Easily	Y / N	Radiation Therapy	Y / N	Rheumatism	Y / N
Artificial Joints (Hip, Knee, etc.)	Y / N	Glaucoma	Y / N	Cortisone Medicine	Y / N

Do you have or have you had any disease, condition, or problem not listed? ..... Yes or No

If yes, please list: \_\_\_\_\_

Do you smoke?.....Yes No      If yes, how much? \_\_\_\_\_

Is there anything you would like us to know about you to make your dental appointments more comfortable? \_\_\_\_\_

WOMEN- Are you pregnant?...Yes No ( \_\_ mos.)    Nursing?...Yes No    Birth Control Pills?..Yes No

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, who may release such information to you. I will notify the doctor of any change in my health or medications.

**Patient or Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I authorize Penrod Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Penrod Dental Care insurance benefits otherwise payable to me.

I consent to the dental practice using my home, cell, work and email to contact me regarding appointments, treatment, insurance and my account.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent if minor) Date

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and DENTAL MATERIALS FACT SHEET

**\*\*You May Refuse to Sign This Acknowledgment\*\***

I, \_\_\_\_\_, have received from Carey L. Penrod, DDS a copy of their Notice of Privacy Practices as well as a copy of the Dental Materials Fact Sheet.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*For office use only:*

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

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