PENROD DENTAL CARE

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

☐ Mailer/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 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 No

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

If yes, please list name(s) and dosage(s)_____

_____

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

Are you aware of having any **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

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

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

Have you ever thought about whitening your teeth…… Yes No

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

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

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

Indicate which of the following you have had or have at present. (Please check **all that apply)**

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

Do you have or have you had any disease, condition, or problem not listed? Yes 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. By typing your name below you agree your electronic signature is the legal equivalent of your manual signature on this document.

Patient or Parent/Guardian Signature_____Date:_____

Doctor Signature:_____Date:_____

Updated Signature_____Date:_____

Updated 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

By typing your name above, you agree your electronic signature is the legal equivalent of your manual signature on this document.

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.

_____

Signature of patient (or parent if minor)

_____

Date

By typing your name above, you agree your electronic signature is the legal equivalent of your manual signature on this document.

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)