Please complete BOTH SIDES of this form so that we may provide you with the best possible dental care. All information is confidential.

WELCOME

ABOUT YOU: Today's date: ____________

Patient name: ____________

What you prefer to be called: ____________

☐ MALE ☐ FEMALE ☐ PREFER NOT TO SAY

Birthdate: ________ Age: ________ SS#: ________

Mailing address:

____

____

Home phone #: (____) ____________

Cell phone #: (____) ____________

Preferred phone #: (____) ____________

E-mail address: ____________

Referred by: ____________

Employer: ____________

Occupation: ____________

Status: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐WIDOWED

Spouse's name: ____________ Any children? ________

PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT:

Name: ____________

Relation: ____________ SS#: ____________

Billing address:

____

____

(initial) ______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

NOTICE OF PRIVACY PRACTICES:

I understand that, under the Heath Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient name: ____________ Date: ________

Relationship to patient: (self or guardian/parent) ____________

Signature of patient or guardian: ____________

DENTAL INSURANCE INFORMATION:

Insurance company name: ____________

Address:

____

Phone #: (____) ____________

Subscriber's ID# or SS#: ____________

Group #: ____________

Subscriber's name: ____________

Relation: ____________ Date of birth: ____________

Insured's employer: ____________

Secondary dental insurance: ____________

Address:

____

____

Phone #: (____) ____________

Subscriber's ID# or SS#: ____________

Group #: ____________

Subscriber's name: ____________

Relation: ____________ Date of birth: ____________

Insured's employer: ____________

IN EVENT OF EMERGENCY:

Whom to contact: ____________

Relation: ____________

Home phone #: (____) ____________

Work phone #: (____) ____________

Cell phone #: (____) ____________

Medical doctor: ____________

Phone #: (____) ____________

CONSENT TO DISCUSS:

By signing this form, I ____________ hereby give permission for Dr. Christine M. Ibinson-Ballew's providers and staff to discuss any issues related to my dental care with the following person(s):

Name: ____________ Relation: ____________

Name: ____________ Relation: ____________

I understand this permission applies to all aspects of my care. This includes treatment, lab results, and billing information.

Patient signature: ____________

PLEASE COMPLETE OTHER SIDE

DENTAL HISTORY:

Reason for today's visit: ______________________ Date of last dental care: ______________

Date of last dental cleaning: ______________________ Date of last dental x-rays: ______________

Former dentist: ______________ Address: ______________________

How often do you brush? ______________ How often do you floss? ______________

Check if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity
- ☐ Periodontal treatment
- ☐ Grinding teeth
- ☐ Food collection between teeth
- ☐ Require a pre-medication

MEDICAL HISTORY:

Physicians name: ______________________ Date of last visit: ______________

Have you ever had any serious illnesses or operations? If yes, describe: ______________

Have you ever had a blood transfusion? If yes, give approximate dates: ______________

Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking birth control pills? ☐ yes ☐ no

List any medications you are currently taking, and the correlating diagnosis:

____

____

____

List any allergies: ____

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Latex sensitivity
- ☐ Liver disease
- ☐ Mitral valve prolapses
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Reflux/GERD
- ☐ Respiratory disease
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tuberculosis
- ☐ Ulcer

Any other medical conditions not listed above:

____

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the information above is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor children ever have a change in health. I certify that I, and/or my dependents, have insurance coverage with ______________________ and assign directly to Dr. Christine M. Ibinson-Ballew all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I authorize the use of my signature for all insurance submissions. The above-named dentist may use my health care information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand it is my responsibility to notify you of any insurance changes.

Signature of patient, parent, guardian, or personal representative:

____ Date: ______________

Please print name of patient, parent, guardian, or personal representative

____ Date: ______________