Tootle & Palmer Dentistry, 600 N. Court Street, Circleville, OH 43113

About You, Our Patient **Today's Date** ________________

Name ____ Birthdate_______________ Sex: M/F

Street Address/P O Box____
City, State & Zip Code ____
Home Phone# __________________, Cell# ___________________, Work# ______________
SS# ________________________, Marital Status___________
Employer ____

Spouse/Partner's Name ________________________________Birthdate ______________
Cell# _________________________, Work# ________________
SS# __________________, Employer ________________________________

Do you have dental insurance? Yes / No -or- Ohio Medicaid benefits? Yes / No

Primary Insurance –or- Medicaid Plan ____
Policy ID# ______________________________, Group# ___________________________
Primary Policy Holder's Name ________________________________ Birthdate _________
Primary Policy Holder's SS# ___________________, Employer _______________________
Relationship to patient _____________________________________

Secondary Insurance –or- Medicaid Plan ____
Policy ID# ______________________________, Group# ______________________________
Secondary Policy Holder's Name _______________________________ Birthdate _________
Secondary Policy Holder's SS# ___________________, Employer_______________________
Relationship to Patient ______________________________________

Student Information (if applicable)
School ____
Full Time / Part Time

Additional Emergency Contact Person
Name ____, Relationship __________________
Home# ____________________________, Cell# ______________________

Previous Dentist ___________________________________, Last App't _________________

Your Medical Information

Primary Care Physician ______________________________________

Office Phone# _______________________

Approximate Date of Last Medical Visit ___/___/_____

YES • NO - Are you currently taking any prescription or over the counter medications, or any natural herbal supplements?

• If yes, please list the medications with dosing (if you have a list please provide for us to copy): ____________________________

BLOOD THINNERS

YES • NO- Are you taking any blood thinners? If yes, please circle:

Aspirin • Coumadin • Plavix • Eliquis • Xarelto • Unknown

BONE DENSITY MEDICATION

YES • NO- Are you taking any medication or IV treatments for bone density (bisphosphonates)? If yes, please circle:

Boniva • Fosamax • Actonel • Atelvia • Reclast • Unknown

PREMEDICATION INFORMATION

The following medical conditions require antibiotic premedication before dental procedures. Do you have or have had any of the following?

YES • NO - Artificial Joints approximate date of surgery ____________

YES • NO - Artificial Heart Valve

YES • NO - Congenital Heart Defects

YES • NO - Previous Bacterial Endocarditis

ALLERGIES

YES • NO - Latex

YES • NO - Penicillin / Amoxicillin

YES • NO - Codeine or other Narcotics

YES • NO - Sulfa Drugs

YES • NO - Iodine

YES • NO - Local Anesthetics : Lidocaine / Articaine / Novacaine

YES • NO - NSAIDS (ibuprofen, naproxen, aspirin)

YES • NO - Metals list ______________________________________

YES – NO - Dyes or Food Coloring

YES – NO - Oils or Flavorings (cinnamon, mint, etc) ________________

YES • NO - Other ______________________________________

Current Dental Information:

YES • NO - Tooth pain or sensivity to hot/cold/ sweets?

YES • NO - Broken teeth or fillings?

YES • NO - Bleeding, swollen, tender gums?

YES • NO - Loose or shifting teeth?

YES • NO - Clenching or grinding your teeth?

YES • NO - Bad breath?

YES • NO - Have you had Orthodontics/Braces?

YES • NO - Do you wear partials or dentures? → Do they fit? YES • NO

*Approximate year Partials/Dentures were made__________

Would you be interested in any of the following to improve your smile?

YES • NO - Whiter Teeth

YES • NO - Straighter Teeth

YES • NO - Replace silver fillings with white fillings

YES • NO - Replace Missing Teeth

Your Medical History

Do you have or have had any of the following?

--CARDIOVASCULAR

YES • NO - Heart Attack date ______________________________

YES • NO - Stroke date ______________________________

YES • NO - High Blood Pressure

YES • NO - Pacemaker

YES • NO - Angina / Chest Pains

YES • NO - Mitral Valve Prolapse

YES • NO - Rheumatic Fever

YES • NO - Heart Murmur → is it congenital? YES • NO

--RESPIRATORY

YES • NO - Asthma

YES • NO - Tuberculosis

YES • NO - Breathing Problems

--GASTRO-INTESTINAL

YES • NO - Kidney Disease

YES • NO - GERD / Reflux / Persistent Heartburn

--NEUROLIGICAL

YES • NO - Seizures / Epilepsy date of last seizure ______________

YES • NO - Mental Health Disorder explain ______________

YES • NO - Dizziness, Fainting, Vertigo, Lightheadedness

--ENDOCRINE & HEMATOLOGY

YES • NO - Diabetes type I / type II

YES • NO - Bleeding Disorder

--INFECTIOUS DISEASE

YES • NO - Hepatitis A B C

YES • NO - HIV / AIDS

YES • NO - Herpes

--OTHER

YES • NO - Current Cancer type ______________________________

YES • NO - Past Cancer type ______________________date _____

YES • NO - Chemo/Radiation therapy date ______________

YES • NO - Alcohol Abuse / Drug Abuse

YES • NO - Tobacco Use Cigarettes / Pipe / Cigars / Smokeless Tobacco

Women:

YES • NO - Are you pregnant? Due Date : ____________

YES • NO - Are you nursing?

YES • NO - Are you taking birth control?

Signature: ___________________________________

Date: ___________________

Medical History Update (yearly review)

Date	Changes	Initials
___/___/___	____	______
___/___/___	____	______
___/___/___	____	______
___/___/___	____	______

CONSENT FORM

Authorization and Release

- I certify that I have read and understand all of the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.
- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for service. I understand that estimates given to me are ONLY ESTIMATES and I am still responsible for any balance not covered by my insurance company. I agree to be responsible for payment of all services rendered on my behalf.

Signature: ____

Date: ___________________

Acknowledgement of Notice of Privacy Practices

(You may refuse to sign this acknowledgement**)

I, ____, understand that this office abides by the HIPAA Law and will protect the privacy
print name
of my personal information. I have been given a copy of this office's notice of privacy practices.

Communication Consent

I give permission to be contacted on the following (check all that apply):

□ Home Phone □ Cell Phone □ Work Phone

Message preference at the above numbers:

□ OK to leave a message with information

□ Leave a message with no information, call back number only

Our office currently confirms appointments via phone calls but may, in the future, want to implement texts or emails. Check if you do NOT want to receive text messages or emails from this office.

□ I DO NOT want to receive texts or emails

Signature: ____

Date: ___________________

Please call us right away if you get a new telephone number!

About your child, Our Patient Today's Date _______________

Name _________________________________ Birthdate__________________ Sex: M/F

Address ____

Parent/Guardian Information (responsible person for account)

Name ____ Relationship____________
Street Address/P O Box____
City, State, Zip Code____
SS# _____________________, Birthdate_______________
Home Phone___________________, Cell #__________________, Work #_______________
Employer ____

Parent/Guardian Information

Name ____ Relationship______________
Address, City & Zip Code ____
SS# _____________________, Birthdate___________________
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Relationship to patient: ______________________________

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Policy ID# ________________________, Group# ________________________________
Secondary Policy Holder's Name ________________________, Birthdate_______________
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School ____
Grade_________________________ Full Time / Part Time

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Name _____________________________________, Relationship _________________
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___/___/___	________________________________	______

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Signature: ____

Date: ___________________

--FOR OFFICE USE ONLY—

We attempted to obtain written acknowledgement for the receipt of our "Notice of Privacy Practices," but acknowledgement could not be

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I give permission to be contacted on the following (check all that apply):

□ Home Phone □ Cell Phone □ Work Phone

Message preference at the above numbers:

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Signature: ____

Date: ___________________

Please call us right away if you get a new telephone number!