

Patient Information



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Let's go →

Basic Information

First Name *

Last Name *

Preferred Name

Date of Birth (MM/DD/YYYY) *

MM/DD/YYYY

Email Address *

Mobile Phone *

 (___) ___-____

Home Phone

 (___) ___-____

Gender *

Family Status

Family Status *

Address

🔍 Type in to search your address

Address Line 1 *

Address Line 2

City *

State *

Zip *

Dental Insurance

Has your dental insurance changed?

What medical conditions do you have?

Select Medical Conditions

Medical conditions not listed

What allergies do you have?

Select Allergies

Allergies not listed

Please add any allergies you don't see in the list above.

What medications are you taking?

Select Medications

Medications not listed

Please add any medications you don't see in the list above.

Do you require premedication (such as antibiotics) before dental treatment? *

- Yes
- No

Preferred Pharmacy

Pharmacy Name *

Pharmacy Phone *

Pharmacy Fax

Pharmacy Address

🔍 Type in to search your address

Address Line 1 *

Address Line 2

City *

State *

Zip

Office Policy

By providing my signature below, I acknowledge that I have reviewed ALL questions/alerts on this form and have responded accordingly. There are no other medical conditions/medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could

be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health information to the following individuals: (This information could include Name, Diagnosis, Test Results, Image and Account Information)

Name


Relationship to Patient

Accept Policy *

Signature *

Draw ▼

Sign here



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