Welcome to Angel Dental Care!

- Please Print:

First: _____ Middle: _____ Last: _____

Address: _____ City, State& Zip: _____

Cell phone: _____ Can we confirm your appointments by text? _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Email: _____ (Your information will be kept confidential).

Patient Social Security Number : _____ (will be used for billing purposes only).

Patient Date of Birth: _____ Age: _____

If under 18, name of parent or guardian: _____ Phone: _____

In case of emergency, whom should we notify?

Name: _____ Phone: _____

How did you hear about us?

☐ Post Card ☐ Referral By: _____

If you saw our ad in a newspaper, please provide name of publication: _____

If you saw us on the internet, please provide name of website: _____

☐ Other: _____

Insurance Information: Do you have Dental Insurance? ___Yes ___No

If yes, please provide:

Primary Insured (If you are the primary subscriber, you may skip this section and go to page 2)		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth:	
Relationship to Subscriber		Relationship to Subscriber	

Name: _____ **Welcome to Angel Dental Care!**

What is your specific dental concern today? _____

Medical History:

In order to treat you safely in the office, knowing your medical history is very important to us. Please answer the following questions to the best of your ability. If you are unsure about a question, or how to answer it, please discuss it with your doctor.

- Have you been under the care of a medical doctor at any time during the past 2 years?.....Yes No
  If yes, please explain:
- Are you currently taking any medications?.....Yes No
  If yes, please list:
- Have you shown allergies to latex or any medication/antibiotics?.....Yes No
  If yes, please specify:
- Please circle which of the following you presently have or have had:

Heart Surgery, Disease, Attack	Y	N	Tuberculosis	Y	N	Smoke/Tobacco	Y	N
Heart Murmur	Y	N	Sinus Problems	Y	N	Alcoholic	Y	N
Heart Pacemaker	Y	N	Cancer	Y	N	Eating Disorder	Y	N
Artificial Valve	Y	N	Radiation	Y	N	Use Habitual Drugs	Y	N
Rheumatic Fever	Y	N	Chemotherapy	Y	N	Anemia	Y	N
Stroke	Y	N	Ulcers	Y	N	Sickle Cell	Y	N
Artificial Joint	Y	N	Arthritis	Y	N	Fen Phen Use	Y	N
High Blood Pressure	Y	N	Hay Fever	Y	N	Osteoporosis Medications	Y	N
Diabetes	Y	N	Herpes	Y	N			
Kidney Trouble	Y	N	Cold Sores/Fever Blisters	Y	N			
Liver Disease	Y	N	Sexually transmitted disease	Y	N			
Hepatitis A, B, C	Y	N	HIV/ AIDS	Y	N			
Asthma	Y	N	Glaucoma	Y	N			
Emphysema	Y	N	Seizures	Y	N			
Fainting Spells	Y	N	Developmentally Disabled	Y	N			
Neurological Disorder	Y	N	Psychiatric Care	Y	N			

- Please list any disease or condition you presently have or have had that is not on this list:

For Women Only: Pregnant? Y N Months? Nursing? Y N Taking Birth Control Pills? Y N

- Do your gums bleed when you brush and floss? Y N
- Do you have history of gum disease and/or gum surgery? Y N Do you grind or clench your teeth? Y N

Authorization & Release:
I certify that all of the preceding answers and information provided are true and correct. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctor at the next appointment. I further certify that I, consent to the performing of x-rays, study models, photographs, examination and any other diagnostic aids deemed appropriate by doctor to make a diagnosis. I authorize the dentist to release my information to third party payer and/or health practitioners.

Patient or Parent Signature: _____ **Date:** _____

For office Use: BP: _____ Pulse: _____ PM: _____ Medical Alert: _____

Medical History reviewed by Doctor _____ Date: _____

Welcome to Angel Dental Care!

Notice of Privacy Practices Acknowledgement:

Under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), you have certain rights to privacy regarding my protected health information. This information can and will be used to:

- Conduct, plan and direct your 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.

You may obtain a copy of the Notice by visiting our website at: http://www.HonestDentistry.com or request one from your health care team.
I acknowledge receipt of the Notice of Privacy Practices of Angel Dental Care.

Signature: _____ **Date:** _____
(patient/parent/conservator/guardian)

Dental Materials Fact Sheet Acknowledgement:

You may obtain a copy of Dental Board of California's Dental Materials Fact Sheet dated October 2001 by visiting our website at:
http://www.HonestDentistry.com or request one from your health care team.

Signature: _____ **Date:** _____
(patient/parent/conservator/guardian)

Office Use Only:

Medical History Update: Initials:

Date:	Comments:	Patient:	Dentist:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____