

Patient's Name _____ Date of Birth _____
Last First Initial

How do you wish to be addressed? _____ Male Female
Single Married Widowed Divorced Name of Spouse _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone: Residence _____ Business _____ Cell Phone _____

Who is responsible for this account? _____

Whom may we thank for this referral? _____

Someone to notify in case of emergency _____

Other family members in this practice: _____

Dental Insurance 1st Coverage

Employee Name _____

Employee Date of Birth _____

Employer _____

Name of Insurance Co. _____

Telephone _____

Membership _____
(Often the same as Social Security #)

Group Number _____

Dental Insurance 2nd Coverage

Employee Name _____

Employee Date of Birth _____

Employer _____

Name of Insurance Co. _____

Telephone _____

Membership _____
(Often the same as Social Security #)

Group Number _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I hereby authorize the use of my radiographs and/or photographs for the use in seminars, publications or for our website.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.

I understand I am financially responsible for payments in full of all accounts. by signing this statement, I agree to pay for services not paid, in whole or in part by my dental insurance carrier. I further agree to a \$5.00 monthly rebilling charge to cover the costs of repeated billing procedures.

I attest to the accuracy of the information on this page.

PATIENT'S SIGNATURE _____ DATE _____

Patient's Name _____
Last First Initial

1. What is the purpose of your visit? _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. When was the last time your teeth were cleaned? _____
6. Past/Previous dentist's name _____ Telephone _____

In the following questions, check yes or no, whichever applies.
If you don't know the correct answer, please write "don't know" on the line after the question.

7. Have you made regular visits? yes no
How often? _____
8. Were full mouth x-rays or a panorex x-ray taken?..... yes no
9. Have you had wisdom teeth removed? yes no
If so, when and where? _____
10. Have you lost any other teeth or have any other teeth been removed?..... yes no
11. Have they been replaced?..... yes no
12. How have they been replaced?
 - a. Fixed bridge _____ Age _____
 - b. Partial denture _____ Age _____
 - c. Full denture _____ Age _____
 - d. Implants _____ Age _____
13. Are you happy with the replacement? yes no
If yes, explain: _____
14. Have you had any other problems or complications with previous dental treatment? yes no
15. Do you clench or grind your teeth?..... yes no
16. Does your jaw click or pop?..... yes no
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?..... yes no
18. Do you have frequent headaches, neckaches or pain in your shoulders?..... yes no
19. Does food get caught in your teeth?..... yes no
20. Are any of your teeth sensitive to: Cold Hot Sweets Pressure
21. Have you noticed any tenderness or swelling in your gums? yes no
22. Do your gums bleed or hurt?..... yes no
23. Have you been instructed on the proper home care of your teeth? yes no
24. What type of toothbrush do you use? Hard Medium Soft Electric (Brand: _____)
25. How often do you brush your teeth? _____
26. Do you floss? If yes, how often? _____
27. What other cleaning aids do you use? _____
28. Have you had any periodontal (gum) treatment? yes no
29. Have you had any orthodontic treatment?..... yes no
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?

I certify that the above information is complete and accurate.

PATIENT'S SIGNATURE _____ DATE _____

Patient's Name _____
Last First Initial

Physician's Name _____ Telephone _____

Are you under the care of specialists? yes no

If yes, please list names and telephone numbers _____

Date of last physical exam _____

In the following questions, please check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

COMMENTS

- | | | | |
|--|-----|----|-------|
| 1. Are you in good health? | yes | no | _____ |
| 2. Are you taking any medications?.....
(If yes, please list medications on the next page of this form) | yes | no | _____ |
| 3. Have you ever been hospitalized? | yes | no | _____ |
| (If yes, please see the next page of this form) | | | |
| 4. Do you have or have you had any of the following? | | | |
| a. Damaged or artificial heart valves? | yes | no | _____ |
| b. Heart murmur? | yes | no | _____ |
| c. Rheumatic fever/Rheumatic Heart Disease?..... | yes | no | _____ |
| d. Heart Ailments (heart failure, heart disease
or heart attack, angina pectoris) | yes | no | _____ |
| e. Cardiac pacemaker | yes | no | _____ |
| 5. Do you have high or low blood pressure? | yes | no | _____ |
| 6. Have you had a stroke?..... | yes | no | _____ |
| 7. Are you allergic to or do you have any problems with
penicillin, antibiotics, anesthetics, or other medications? | yes | no | _____ |
| (If yes, please refer to the next page of this form) | | | |
| 8. Do you have any other allergies? | yes | no | _____ |
| 9. Do you have sinus troubles? | yes | no | _____ |
| 10. Do you have asthma?..... | yes | no | _____ |
| 11. Do you or have you had tuberculosis (TB)? | yes | no | _____ |
| 12. Do you have any artificial joints (hip, knee)?..... | yes | no | _____ |
| 13. Do you have any inflammatory diseases, such
as arthritis or rheumatism? | yes | no | _____ |
| 14. Do you have any blood disorders such as
anemia, leukemia, etc? | yes | no | _____ |
| 15. Have you ever bled excessively after
being cut or injured? | yes | no | _____ |
| 16. Are you diabetic? | yes | no | _____ |
| 17. Do you have any stomach problems? | yes | no | _____ |
| 18. Do you have any kidney problems? | yes | no | _____ |
| 19. Do you have any liver problems? | yes | no | _____ |
| 20. Have you had or do you test positive for hepatitis?..... | yes | no | _____ |
| 21. Have you had psychiatric care? | yes | no | _____ |
| 22. Do you have epilepsy or seizure disorders?..... | yes | no | _____ |
| 23. Do you have glaucoma?..... | yes | no | _____ |

Please continue on the next page

24. Do you have thyroid disease? yes no _____
25. Have you had or do you have cancer? yes no _____
26. Have you ever had radiation treatment or chemotherapy for tumor, growth or other condition? yes no _____
27. Do you have or have you had any venereal disease? yes no _____
28. Have you tested HIV positive? yes no _____
29. Do you have AIDS? yes no _____
30. Do you use tobacco products? yes no _____
31. Do you have any disease, condition or problem not listed? If so, please explain.

32. Is there anything else we should know about your health that we have not covered in this form?

33. Would you like to speak to the doctor privately about any problems? yes no _____

For Women Only:

34. Are you pregnant? yes no _____
If yes, what month? _____

35. Are you taking birth control pills? yes no _____

Medications

Drug Name	Dosage	Reason
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Hospitalization

Date	Purpose	Outcome1.
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Are you allergic or have you reacted adversely to any of the following?

Aspirin Penicillin Other antibiotics Codeine Latex Local anesthetics Other

I certify that the above information is complete and accurate. I acknowledge that I am responsible for informing the doctor about changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment.

PATIENT'S SIGNATURE _____ DATE _____

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sharon Karabin

Telephone: 410-665-2202 Fax: 410-665-9008 E-mail: info@tmjbaltimore.com

Address: 9010 Harford Road, Baltimore, MD 21234

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

I, _____ have received a copy of this office's
Notice of Privacy Practices.

(Please Print Name) _____

(Signature) _____

(Date) _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented from obtaining acknowledgement
- Other (Please Specify)

Under certain circumstances it may be necessary for our dental hygienists to provide services prescribed by your dentist who will not be present. Of course you will be informed prior to your appointment. For this purpose we require your consent in writing prior to receiving the hygiene services.

Signature _____