

# *Welcome to our Practice!*

*Will you please help us by providing us with the following confidential information?*

## **PATIENT INFORMATION:**

E-mail Address: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred to be called: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Driver's License: \_\_\_\_\_ Sex:   M     F   Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address, City State, Zip \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # : \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Address (if different than above): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address, City, State, Zip: \_\_\_\_\_

**In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:**

**Phone number:** \_\_\_\_\_ **Place** \_\_\_\_\_ **Time:** \_\_\_\_\_

How did you hear about our office? Please check:  Internet Search  Patient referral  Website  Radio Ad  Yellow Pages  Other \_\_\_\_\_

## **INSURANCE INFORMATION:**

**Primary** Insurance Company : \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_

Group# or Policy # \_\_\_\_\_

**I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Farnham of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.**

**Date:** \_\_\_\_\_ **Patient's Signature:** \_\_\_\_\_

# HIPAA PRIVACY FORM

## Acknowledgement of Receipt of Notice of Privacy Practices

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**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_, have received a copy/explanation of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Signature of Patient and/or Guardian} {Date} \_\_\_\_\_

(Relationship to Patient) Self or Other: \_\_\_\_\_

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### For Office Use Only

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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 (such as a language barrier) prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement at time of service
- Other (Please specify)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HEALTH HISTORY**

**PATIENT NAME:** \_\_\_\_\_

**A. CIRCLE YOUR ANSWERS** (leave BLANK if you do not understand the question):

- 1. Yes No Are you in good health?
- 2. Yes No Has there been a change in your health within the last year? Explain: \_\_\_\_\_
- 3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: \_\_\_\_\_

- 4. Yes No Are you being treated by a physician now? For what? \_\_\_\_\_

Name of your physician: \_\_\_\_\_ Date of last Medical Exam: \_\_\_\_\_

**B. HAVE YOU EVER EXPERIENCED?**

- |  |   |
|--|---|
| 5. Yes No Chest Pains                              | 16. Yes No Dizziness                      |
| 6. Yes No Swollen Ankles                           | 17. Yes No Ringing in ears                |
| 7. Yes No Shortness of breath                      | 18. Yes No Frequent Headaches             |
| 8. Yes No Recent weight loss, fever, night sweats  | 19. Yes No Fainting spells                |
| 9. Yes No Persistent cough, coughing up blood      | 20. Yes No Blurred Vision                 |
| 10. Yes No Bleeding problems, bruising easily      | 21. Yes No Seizures                       |
| 11. Yes No Sinus Problems                          | 22. Yes No Excessive thirst               |
| 12. Yes No Difficulty swallowing                   | 23. Yes No Frequent urination             |
| 13. Yes No Diarrhea, constipation, blood in stools | 24. Yes No Dry Mouth                      |
| 14. Yes No Frequent vomiting, nausea               | 25. Yes No Jaundice                       |
| 15. Yes No Difficulty urinating, blood in urine    | 26. Yes No Joint pain, stiffness          |
|  | 27. Yes No Sleep apnea or chronic snoring |

**C. DO YOU HAVE OR HAVE YOU HAD:**

- |   |  |
|---|--|
| 28. Yes No Heart disease                                      | 39. Yes No HIV positive or AIDS-ARC  |
| 29. Yes No Heart attack, heart defects                        | 40. Yes No Tumors, Cancer  |
| 30. Yes No Heart murmur                                       | 41. Yes No Arthritis, rheumatism   |
| 31. Yes No Rheumatic fever                                    | 42. Yes No Eye disease   |
| 32. Yes No Stroke, hardening of arteries                      | 43. Yes No Skin disease  |
| 33. Yes No High Blood Pressure                                | 44. Yes No Anemia  |
| 34. Yes No TB, emphysema or other lung diseases               | 45. Yes No VD (syphilis or gonorrhea)  |
| 35. Yes No Hepatitis, A B C                                   | 46. Yes No Herpes  |
| 36. Yes No Stomach problems, ulcers                           | 47. Yes No Kidney, bladder diseases  |
| 37. Yes No Diabetes   | 48. Yes No Thyroid, adrenal diseases   |
| 38. Yes No Family History of diabetes, heart problems, cancer | 49. <b>ALLERGIES:</b> to drugs, food, medications, metals, jewelry, acrylics; <b>list the following allergies:</b> |

**D. DO YOU HAVE OR HAVE YOU HAD:**

- |                                     |   |
|-------------------------------------|---|
| 50. Yes No Surgeries _____          | 55. Yes No Radiation Treatments                   |
| 51. Yes No Blood Transfusions _____ | 56. Yes No Chemotherapy                           |
| 52. Yes No Artificial Joint _____   | 57. Yes No Prosthetic heart valve                 |
| 53. Yes No Contact Lenses _____     | 58. Yes No Pacemaker                              |
| 54. Yes No Psychiatric Care _____   | 59. Yes No <b>Women only:</b> Birth Control Pills |
|                                     | 60. Yes No <b>Women only: Pregnant or nursing</b> |

**E. DO YOU TAKE OR HAVE TAKEN:**

- 61. Yes No Recreational drugs
- 62. Yes No Alcohol
- 63. Yes No Tobacco in any forms
- 64. Yes No Phen Phen diet Pills or any other diet pills
- 65. Yes No Bisphosphonates: Fosamax,

**VITAMINS & MEDICATIONS:** \_\_\_\_\_

**F. ALL PATIENTS:**

- 66. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

- 67. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

## DENTAL HEALTH HISTORY

G. Name of your Former Dentist: (optional) \_\_\_\_\_ How long since you were last seen? \_\_\_\_\_

68. Is keeping your teeth important to you? [Y] [N] If yes, why? \_\_\_\_\_

69. On a scale of 1-10, 10 being the best, where would you rate your smile?

70. On a scale of 1-10, 10 being the best, where you rate your oral health?

71. Have you experienced any of the following problems:

Bleeding gums [Y] [N],

Bad Breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N],

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Had your parents suffered from Gum Disease? [Y] [N]

Did you ever wear braces? [Y] [N]

Oral Surgery of any kind? [Y] [N]

Sensitivity to Hot & Cold [Y] [N]

Snoring [Y] [N]

Food catching between teeth [Y] [N]

Grinding of Teeth [Y] [N]

Pain/soreness around ears, eyes, face [Y] [N]

Stiff neck muscles [Y] [N]

Did you parents wear dentures/partials? [Y] [N]

Ever been injured in your mouth or head? [Y] [N]

Do you smoke or chew tobacco? [Y] [N]

72 Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? \_\_\_\_\_

73. Is the brightness of your teeth important to you? [Y] [N]

74. If you could change anything about your smile which of the following would you want] ?

Whiter [Y] [N]

Close space or spaces [Y] [N]

Replace chipped teeth [Y] [N]

Replace missing teeth [Y] [N]

Replace old crowns [Y] [N]

Remove silver fillings [Y] [N]

Remove Stains/Spots on teeth [Y] [N]

Excess showing of Teeth [Y] [N]

Replace old plastic filling(s) [Y] [N]

Straighter [Y] [N]

Less Gum showing [Y] [N]

Reshape/resize my teeth [Y] [N]

75. Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?

**Please circle the following which are important to you when making your dental health decision.**

Convenience

Appearance

Relationship with Dental Team

Finances

Time

Quality of care

What insurance covers

Health

Detailed treatment explanations

Fear or Anxiety

Comfort

Technology