AXIOM DENTISTRY

Patient Information

Date _____ SS/HIC/Patient ID# _____
Patient Name _____ Preferred Name _____
Address _____ City _____ State _____ Zip _____
Sex ❑ M ❑ F Age _____ Birth Date _____ Email _____
❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑ Single ❑ Minor ❑ Partner for _____ years
Occupation _____ Patient Employer/School _____
Employer/School Address _____
Employer/School Phone Number _____

Spouse's Name _____ Birthdate _____
SS# _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Best time to and place to reach you _____
Home _____ Work _____ Cell _____
Spouse's Work _____ Spouse's Cell _____
IN CASE OF EMERGENCY, CONTACT (Specify someone outside your household)
Name _____ Relationship _____
Home Phone _____ Work _____

Dental Insurance

Who is responsible for this account? _____ Relationship to Patient _____
Insurance Co. _____ Phone _____
Group # _____
Subscriber's Name _____
Birthdate _____ SS# _____ Relationship to Patient _____

Assignment And Release

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the avboe-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and detaermining insurance beneifi6ts or the beneifts payable for related services. This consent will end when my cuurent treatment plan is completed or one year from the date signed below.

Dental History

Reason for today's visit _____ Former Dentist _____ City/State _____
Date of last dental visit _____ Date of last dental x-rays _____

Please indicate if you have had any of the following:

Bad breath	❑ Yes ❑ No	Food collection between teeth	❑ Yes ❑ No	Orthodontic treatment	❑ Yes ❑ No
Bleeding gums	❑ Yes ❑ No	Foreign objects	❑ Yes ❑ No	Pain around ear	❑ Yes ❑ No
Blisters on lips or mouth	❑ Yes ❑ No	Grinding teeth	❑ Yes ❑ No	Periodontal treatment	❑ Yes ❑ No
Burning sensation on tongue	❑ Yes ❑ No	Gums swollen or tender	❑ Yes ❑ No	Sensitivity to cold	❑ Yes ❑ No
Chew on one side of mouth	❑ Yes ❑ No	Jaw pain or tiredness	❑ Yes ❑ No	Sensitivity to heat	❑ Yes ❑ No
Cigerette, pipe, or cigar smoking	❑ Yes ❑ No	Lip or cheek biting	❑ Yes ❑ No	Sensitivity to sweets	❑ Yes ❑ No
Clicking or popping jaw	❑ Yes ❑ No	Loose teeth or broken fillings	❑ Yes ❑ No	Sensitivity to when biting	❑ Yes ❑ No
Dry mouth	❑ Yes ❑ No	Mouth breathing	❑ Yes ❑ No	Sores or growns in your mouth	❑ Yes ❑ No
Fingernail bitting	❑ Yes ❑ No	Mouth pain, brushing	❑ Yes ❑ No	How often do you floss?	_____
				How often do you brush?	_____

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Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondlmin (fenfluramine) & Redux (dexfenfluramine). ❑ Yes ❑ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis Type _____	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Bleeding abnormally,		Herpes	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
with extractions or surgery	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Swollen Feet or Ankles	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tumor or growth on head	
Congenital Hear Lesions	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	or neck	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Weight Loss, unexplained	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No		

Have you ever been prescribed any bisphosphonate drugs such as Fosamax, Boniva, Actonel, Arcdia, Zometa, Bonatos, Ostec, Skeklid, Didtonel for Osteoporosis or other conditions? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Women:

Are you Pregnant? ❑ Yes ❑ No Due date _____ Are you nursing? ❑ Yes ❑ No

Taking Birth control pills? ❑ Yes ❑ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone _____

Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other

Updates

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? ❑ Yes ❑ No if so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Acknowledge of Receipt Of Notice of Privacy Practices

Patient Name _____

Address _____

_____

I have received copy of the Notice of Privacy Practices for the above named practice.

_____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail
- ❑ Unable to communicate with the patient for the following reason:

_____

- ❑ Other, please list:

_____

_____

_____

_____

Prepared By _____

_____

Signature Date

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Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with patient's instructions.

Entity to Receive Information	Description of information to be released
Check each person/entity that you approve to receive information.	Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab test/x-rays ❑ Other
❑ Spouse	❑ Financial ❑ Medical ad follows
❑ Parent (provide name)	❑ Financial ❑ Medical as follows
❑ Other (provide name)	❑ Financial ❑ Medical as follows

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient.**

_____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

_____

_____