PATIENT INFORMATION

Welcome to OC Dentistry! Thank you for partnering with us for your dental needs.
The following personal information is requested and will be kept confidential in your patient chart.

Today's Date _____

How did you hear about our office? _____

Patient's name _____ Sex: M F
Last name First name Middle name

Birth Date**:** _____ Social Security # _____ /_____ /_____ Driver's License # _____

Address _____

City _____ State _____ Zip _____

Home Phone # ( )_____

Cell Phone # ( )_____ Can we send texts to your cell phone? Yes No

E-mail: _____ Can we send you emails? Yes No

Guardian (if minor) _____ Relationship to minor: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

INSURANCE INFORMATION

We intend for you to be fully informed about your insurance coverage and benefits. Rest assured that prior to starting any treatments, we will review the costs involved in your treatment plan and explain how your insurance will cover those costs.

We, at OC Dentistry, take the matter of insurance fraud very seriously and we do not participate in any form of insurance fraud, which includes the waiving of deductibles and copayments as well as billing for services not rendered.

Name of Insurance Carrier: _____ Group Policy # _____

Insured Person's Name:_____ Insured Person's Subscriber ID _____

Insured Person's Birth Date: _____ Relationship to the Insured Person: _____

Do you have a secondary insurance? No Yes:

If yes, please provide the following information:

Name of Insurance Carrier: _____ Group Policy # _____

Insured Person's Name:_____ Insured Person's Subscriber ID _____

Insured Person's Birth Date: _____ Relationship to the Insured Person: _____

MEDICAL HISTORY

Are you under the care of a physician to treat **ongoing** condition? Yes No

If yes, please specify the condition: _____

Are you taking any medications? Yes No

If yes, please list each one below:

Medication (Drug Name)	Reason (Medical Condition)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(If you need more space, please list the remaining medications on the back of this page.)

Are you taking any non-prescription drugs? Yes No

If yes, please specify: _____

Please indicate with a check mark ☑ if you **ever had** any of the following:

Abnormal bleeding
Alcohol/drug abuse
Anemia
Arthritis /Rheumatism
Artificial heart valve
Artificial joints/ bones (total joint replacements)
Asthma
Back problems
Blood transfusion
Cancer/ chemotherapy/ radiation therapy
Colitis
Congenital Heart Defect –unrepaired, incomplete
Cortisone treatments
Diabetes
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery / Transplant
Hemophilia
Hepatitis
Herpes/Fever Blisters
High Blood Pressure
Low Blood Pressure
HIV+ / AIDS
Infective Endocarditis
Kidney Problems
Liver Disease
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems, specify:
_____
Rheumatic / Scarlet Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Thyroid Problems
Cigarettes / Tobacco Use
Tuberculosis (TB)
Ulcers
Other
_____
_____

For women only:

Are you pregnant?	Yes	No	** Xrays will not be taken during 1st trimester
Are you taking birth control pills?	Yes	No	** Antibiotics decrease the effectiveness of
Are you nursing?	Yes	No	birth control pills

Are you allergic to any of the following?

Aspirin	Latex gloves	Other
Codeine	Metals	_____
Dental anesthetics	Penicillin	_____
Erythromycin	Sulfa	_____
Jewelry	Tetracycline	

Was your allergy diagnosed by a physician? Yes No

The above medical history is accurate and complete to the best of knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____

Acknowledgment of Privacy Practices (HIPAA)

I understand that my personal and health information will be used to:

- Provide and coordinate my treatment among health care providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand that I may request in writing that my dental provider restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that my dental provider is not required to agree to my requested restrictions, but if he does agree then he is bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____

Relationship to Patient _____

Dependent family members also covered by this ACKNOWLEDGMENT.

TERMS AND CONDITIONS:

Please read the terms and conditions carefully. This is a binding agreement.

** The office reserves the right to refuse service to anyone.

** The office requires a 48 hour notice to cancel/reschedule an appointment. A $120.00 charge will be imposed after the 2nd missed/cancelled appointment without a 48 hour notice.

** All balances must be cleared. No appointments will be made for any member within a family account if there is any unpaid balance on the subscriber's account or a dependent's account.

** Hostile / threatening behavior will result in dismissal from the office and you will be prosecuted to the fullest extent of the law.

Refusal to agree to the terms of our office is voluntary dismissal.

Patient's or Legal Guardian's Signature _____

Name (print) _____

Date _____