The ToothBooth

Welcome to The ToothBooth- Tell Us About Yourself

Name: _____
Last First Preferred Name

Male Female Marital Status: Single Married Divorced Widowed Separated Domestic Partner

DOB: _____ AGE: _____ SSN: _____

Mailing Address: _____ City _____ State _____ ZIP _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ May we leave a message or text on this phone? ❑Yes ❑ No

E-mail Address: _____ Employer: _____

How did you hear about our office? _____

Name and phone number of nearest relative? _____

Relation: _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name and address _____

Insurance Company Phone: _____ Group Number: _____

Assignment, Release, and Consent

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to The ToothBooth 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I understand that should I default on payment of my account & collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

Responsible Party Signature (Patient/Guardian): _____

Relationship: _____ Date: _____

Please know, we value each and every one of our patients. To provide the best possible care to all of you, we appreciate a 48-hour notice for appointment changes or cancellations. Without providing this notice, it is possible to lose your patient status at our office.

_____ _____

Sign Date

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name and Phone #:_____

Have you had any joints replaced? ❑ Yes ❑ No

If so, where and when? _____

Are you taking any medications (including aspirin)? ❑ Yes ❑ No

Please list each one: _____

Do you use tobacco in any form? ❑ Yes ❑ No

If yes, what kind and how much: _____

Yes No	Conditions	Yes No	Conditions	Yes No	Conditions
❑ ❑	Abnormal Bleeding	❑ ❑	Glaucoma	❑ ❑	Sickle Cell Disease
❑ ❑	Alcohol Abuse	❑ ❑	HIV+ AIDS	❑ ❑	Sinus Problems
❑ ❑	Allergies	❑ ❑	Heart Attack	❑ ❑	Stroke
❑ ❑	Anemia	❑ ❑	Heart Murmur	❑ ❑	Thyroid Problems
❑ ❑	Angina Pectoris	❑ ❑	Heart Surgery	❑ ❑	Tuberculosis
❑ ❑	Arthritis	❑ ❑	Hemophilia	❑ ❑	Ulcers
❑ ❑	Artificial Heart Valve	❑ ❑	Hepatitis A		
❑ ❑	Asthma	❑ ❑	Hepatitis B		
❑ ❑	Blood Transfusion	❑ ❑	Hepatitis C		
❑ ❑	Cancer	❑ ❑	High Blood Pressure		
❑ ❑	Chemotherapy	❑ ❑	Joint Replacement		
❑ ❑	Colitis	❑ ❑	Kidney Problems		
❑ ❑	Congenital Heart Defect	❑ ❑	Liver Disease		
❑ ❑	Diabetes	❑ ❑	Low Blood Pressure		
❑ ❑	Difficulty Breathing	❑ ❑	Mitral Valve Prolapse		
❑ ❑	Drug Abuse	❑ ❑	Pace Maker		
❑ ❑	Emphysema	❑ ❑	Psychiatric Disorders		
❑ ❑	Epilepsy	❑ ❑	Radiation Therapy		
❑ ❑	Facial Surgery	❑ ❑	Rheumatic Fever		
❑ ❑	Fainting Spells	❑ ❑	Seizures		
❑ ❑	Fever Blisters	❑ ❑	Sexually Transmitted Disease		
❑ ❑	Frequent Headaches	❑ ❑	Shingles		

Yes No	Allergies ❑Yes ❑ No
❑ ❑	Aspirin
❑ ❑	Codeine
❑ ❑	Dental Anesthetics
❑ ❑	Erythromycin
❑ ❑	Jewelry
❑ ❑	Latex
❑ ❑	Metals
❑ ❑	Penicillin
❑ ❑	Tetracycline
❑ ❑	Other:_____

Yes No	If Female, Please Answer
❑ ❑	Are you taking Birth Control Pills?
❑ ❑	Are you pregnant? If so, # of Weeks _____
❑ ❑	Are you nursing?

Dental History

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

How many times a day do you: brush? _____ floss? _____

When was your last dental visit? _____ dental cleaning? _____

Who is your prior dentist/Why did you leave?_____

How can we accommodate you better during your dental visit?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*You may refuse to sign this acknowledgment

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

_____

Print name and phone numbers of anyone allowed information- ER CONTACT, Adults who may bring children, Spouse's who may make appointments, etc.

_____

Signature

_____

Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)