Welcome to our office!!

Name: ____
Last First MI Title

Preferred Name: ___________________________________ ☐ Male ☐ Female DOB: ________________

Address: ____City: _______________ State: ______ Zip: __________

SS#: ____________________ Driver License: ________________E-mail Address: ______________________________

Home Phone: _______________________ Work Phone: _______________________Cell Phone: ___________________

Employer: ____ Occupation: ____________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? ____

Emergency contact person and phone number: ____

Patient Consent for Electronic Communication

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that **Benoit Family Dental** may send to you any of the following that you identify as communication that can be sent through phone (text) or the internet to an email address you designate.

Consent and Acknowledgement

I____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address_______________________________________

I acknowledge that the practice may send the following to my email/phone. Check each that apply and then provide your initials at the end of each item selected.

☐ Information about my invoice or accounts payable. ______(initials)

☐ Information about a specific dental visit. ______ (initials) Specify__________

☐ Information about any dental visit. ______ (initials)

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

_______All electronic communications from our practice will be encrypted.

_______I am responsible for providing the dental practice any updates to my email address.

_______I am able to receive information electronically and store it securely away from any public computer.

_______I can withdraw my consent to electronic communications by calling ***713-529-3069*****.**

Consent of Notice of Privacy Practices

I acknowledge that I have read and understand the HIPAA Notice of Privacy Practices for Protected Health Information.

Patient's Signature____ Date________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

☐ YES ☐ NO Cancer or tumor
☐ YES ☐ NO Heart ailment or angina
☐ YES ☐ NO Heart Murmur, mitral valve prolapse Heart defect
☐ YES ☐ NO Rheumatic fever or rheumatic heart disease
☐ YES ☐ NO Artificial joint or valve
☐ YES ☐ NO High or low blood pressure
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Tuberculosis or other lung problems
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Hepatitis or other liver disease
☐ YES ☐ NO Alcoholism
☐ YES ☐ NO Blood transfusion
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Neurologic condition
☐ YES ☐ NO Epilepsy, seizures, or fainting spells
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Herpes or cold sores
☐ YES ☐ NO AIDS or HIV positive
☐ YES ☐ NO Migraine headaches or frequent Headaches
☐ YES ☐ NO Anemia or blood disorders
☐ YES ☐ NO Abnormal bleeding after extractions, Surgery, or trauma
☐ YES ☐ NO Hayfever or sinus trouble
☐ YES ☐ NO Allergies or hives
☐ YES ☐ NO Asthma

Do you smoke or use chewing tobacco? ☐ YES ☐ NO

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

☐ YES ☐ NO Latex materials
☐ YES ☐ NO Penicillin or other antibiotics
☐ YES ☐ NO Local anesthetics (“Novocain”)
☐ YES ☐ NO Codeine or other narcotics
☐ YES ☐ NO Sulfa drugs
☐ YES ☐ NO Barbiturates, sedatives, or sleeping pills
☐ YES ☐ NO Aspirin
☐ YES ☐ NO Other:

____

Are you taking any of the following

☐ YES ☐ NO Aspirin
☐ YES ☐ NO Anticoagulants (blood thinners)
☐ YES ☐ NO Antibiotics or sulfa drugs
☐ YES ☐ NO High blood pressure medicine
☐ YES ☐ NO Antidepressants or tranquilizers
☐ YES ☐ NO Insulin, Orinase, or other diabetes drug
☐ YES ☐ NO Nitroglycerin
☐ YES ☐ NO Cortisone or other steroids
☐ YES ☐ NO Osteoporosis (bone density) medicine
☐ YES ☐ NO Other:

____
____

Women:

☐ YES ☐ NO May be pregnant
Expected delivery date: _____
☐ YES ☐ NO Taking hormones or contraceptives

Physician Name: ______________________________

Physician Phone Number: ______________________

List any medication you are taking: ____
____
____

Do you have any disease, condition, or problem not listed above? ______________________________
____
____

Please add anything else you would like us to know about your oral hygiene: ______________________
____
____

Signature of patient (or parent): ______________________________________

Date: __________________