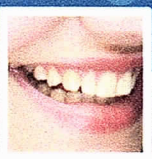
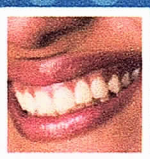
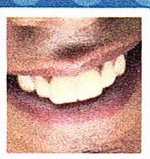
Dental Arts
704 2nd Avenue SW
Cullman, AL 35055

(256)739-5533
info.dentalarts@gmail.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: * _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: * _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: * _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address: * _____ _____

* _____ * _____ * _____
City State Zip Code

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____
City State Zip Code

Spouse/Parent or Guardian name and phone numbers:

_____

Emergency Contact and phone numbers:

* _____

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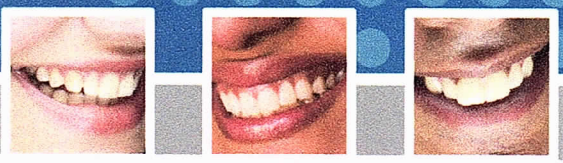

Whom may we thank for referring you to our practice?

*

Dental History

Date of last Dental Visit and Xrays?

Previous Dentist's name and phone number?

Do you have any dental complaints or concerns about your smile?

◯ Yes ◯ No

If yes, please describe:

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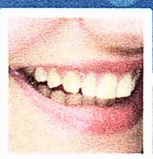
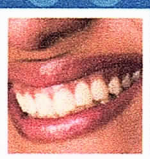
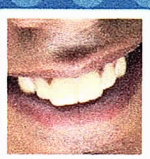

Medical History

Please list your physician and phone number:

Have you had any recent hospitalizations or surgeries? if so, please list.

Please list any medications, herbal remedies or supplements you are taking:

Do you or have you ever taken bone loss prevention drugs such as Fosamax, Boniva or any other bisphosphonates? If yes, please list name and dosage:

Are you required by a physician to take antiobiotic pre-medication before dental appointments?

◯ Yes ◯ No

Do you smoke/use tabacco? If so how much?

Have you ever undergone treatment for alcohol or drug abuse?

◯ Yes ◯ No

Ladies: Are you pregnant, or do you think you may be pregnant? If yes, when is your due date?

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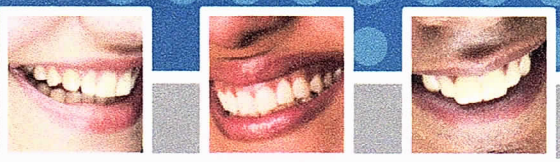

- [ ] Allergy-Amoxicillan
- [ ] Allergy-Anesthetics
- [ ] Allergy-Clindamycin
- [ ] Allergy-Codeine
- [ ] Allergy-Erythromycin
- [ ] Allergy-Hydrocodone
- [ ] Allergy-Latex
- [ ] Allergy-Penicillin
- [ ] Anemia
- [ ] Angina/Chest Pain
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Cardiac Pacemaker
- [ ] Chemotherapy
- [ ] Diabetes
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Gum Treatment
- [ ] Head Injury
- [ ] Heart Attack
- [ ] Heart Condition
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Stints/Shunts
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Hydrocodone allergy
- [ ] Immune Deficiency
- [ ] Joint Replacement
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Other/Allergies
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism/Arthritis
- [ ] Sinus/Hay Fever
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] TMJ
- [ ] Tuberculosis
- [ ] Tumors/Growths
- [ ] Venereal Disease

Consent for Services

I hereby give Dental Arts the right and permission to use my photographs/imaging for educational or promotional purposes. I release any right to present or future compensation in connection with the use of said photographs/imaging.

- [ ] By checking this box, I acknowledge that I have read the statements above and agree to the contents.

Response Date: _____

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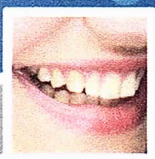
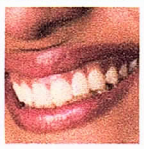
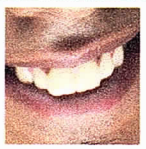

Dental Insurance Information

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Policy holder's social security number:

_____

Secondary Dental Insurance

◯ Yes ◯ No

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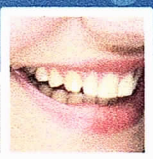
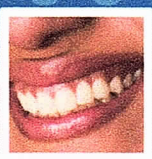
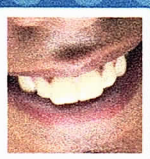

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

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Policy holder's social security number:

_____

Response Date: _____

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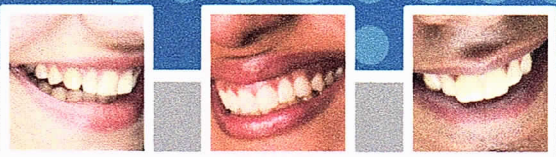

Consent for Internet Communications

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____