PATIENT INFORMATION

Date _____/_____/_____

Given Name _____ Birthdate _____/_____/_____
Social Security # _____-_____-_____ Address _____
City _____ State _____ Zip _____ Home Phone (_____) _____-_____
Cell Phone (_____) _____-_____ Email Address _____
Check Appropriate: Minor Single Married Divorced Widowed Separated
You or your Parent/Guardian's Employer _____ Work Phone (_____) _____-_____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's name _____ Employer _____
If you are a College Student, Name of School _____ Student Status FT PT
Whom may we thank for referring you? _____
Person to contact in case of an emergency _____ Phone Number (_____) _____-_____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____-_____ Cell Phone (____) _____-_____ Birthdate _____/_____/_____
Social Security # _____-_____-_____ Email Address _____
Employer _____ Work Phone (____) _____-_____
Is this person a patient at our office Yes No

INSURANCE INFORMATION

Name of the subscriber _____ Relationship _____
Birthdate _____/_____/_____ Social Security # _____-_____-_____ ID # _____
Employer _____ Date employed _____/_____/_____
Address of Employer _____ City _____ State _____ Zip _____
Is your insurance through your employer? Yes No
Insurance Company_____ Group Name _____ Group # _____
Insurance Address _____ City _____ State _____ Zip _____
Insurance Phone Number (____) _____-_____ How much is your deductible $ _____
How much is your maximum $ _____ How much of your maximum have you used $_____

SECONDARY INSURANCE INFORMATION

Name of the subscriber _____ Relationship _____
Birthdate _____/_____/_____ Social Security # _____-_____-_____ ID # _____
Employer _____ Date employed _____/_____/_____
Address of Employer _____ City _____ State _____ Zip _____
Is your insurance through your employer? Yes No
Insurance Company_____ Group Name _____ Group # _____
Insurance Address _____ City _____ State _____ Zip _____
Insurance Phone Number (____) _____-_____ How much is your deductible $ _____
How much is your maximum $ _____ How much of your maximum have you used $_____

I understand I am responsible for the accuracy of the insurance information that I am giving. I understand it is my responsibility to know my coverage, deductible, and maximum allowed per year for my insurance. I understand any information given by Dr. John C. Carter's office or my insurance company is not a guarantee of payment.

Signature SSN Date

Please turn over and fill out the back side completely

MEDICAL HISTORY

Physician's Name _____ Phone Number (____) _____-_____
Date of last visit _____/_____/_____ (Women) Are you pregnant? Yes No If yes, dates _____
Have you had any serious illnesses or operations? Yes No If Yes, explain. _____
_____
Are you currently under medical treatment? If yes, explain. _____
List all the medications you are taking _____
Are you allergic to or have had reactions to:
Penicillin Sulfa Drugs Latex Local Anesthetics Other _____
Specialist Doctor Information for heart/implants/joint replacement/etc. (or put any additional information here) ___
_____

	Yes	No		Yes	No
High Blood Pressure			On a blood thinner?		
Heart Attack			- Which one _____		
-Date _____			Have an implant of any kind?		
Heart Disease			- Explain _____		
Heart Murmur			Emphysema		
- Organic or Functional			Arthritis		
Stroke			-Where _____		
Asthma			Joint Replacement		
-Do you use an inhaler?			-Explain _____		
Epilepsy/Convulsions			Mitral Valve Prolapse		
Diabetes			Migraines		
-NIDDM or IDDM			Cardiac Pacemaker		
AIDS/HIV			Blood Disorder		
Hepatitis _____			-Explain _____		
Thyroid			Psychiatric Treatment		
-Hyper or Hypo			-Explain _____		
Cancer			Respiratory problems		
-Dates _____			- Explain _____		
Radiation Therapy			Do you require a Pre-med?		
-Dates _____			- Which one _____		
Leukemia					

DENTAL HISTORY

	Yes	No		Yes	No
Teeth Sensitivity			Do you have removable dentures?		
- Hot, Cold, Sweets, Pressure			Manual brush (soft, med, hard)		
Bleeding Gums			-_____		
Halitosis/Unpleasant taste in mouth			Electric brush (spin, sonicare)		
Food impaction area in between teeth			-Brand _____		
Fingernail, Cheek Biting			Mouth rinse?		
Complications from extractions			-Brand _____		
-Explain _____			Do you whiten your teeth?		
Mouth breathing			-How _____		
Diagnosed TMJ?			Water pik- other hygiene aids		
-When _____			-Explain _____		
Jaw problems			Have you ever had chairside whitening?		
-Explain _____			-When _____		
Frequent Headaches			Fluoride Rinse or gel?		
Smoker			-Brand _____		
-How often _____			Orthodontics		
Chew/Dip User			-Dates _____		
-How often _____			What brand of tooth paste do you use? _____		

_____ times a day for brushing _____ times a day for flossing
If you are a new patient, who was you're your last dentist? _____ Date of last cleaning ____/____/_____

Patient Consent Form/HIPPA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected insurance health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (e.g. my insurance company), the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice or Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____
Signature Date

_____
Parent print name and sign if for a minor Date