

PATIENT INFORMATION	
Date: _____	<input type="checkbox"/> NEW PATIENT <input type="checkbox"/> UPDATE
Patient: _____	
LAST FIRST MI PREFERRED TITLE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> CHILD* <input type="checkbox"/> STUDENT** <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: _____ PARENT/GUARDIAN NAME(S)	**IF STUDENT, PLEASE COMPLETE: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME _____ SCHOOL/LOCATION
Patient Date of Birth: _____	Patient SSN: _____
Address: _____ ADDRESS LINE 1	HOME: _____
_____	CELL: _____
ADDRESS LINE 2	OTHER: _____
CITY ST ZIP CODE	PAGER: _____
E-Mail: _____	FAX: _____
Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____	

MEDICAL HISTORY UPDATES	
GENERAL HEALTH: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	
<input type="checkbox"/> Y <input type="checkbox"/> N Under a physician's care now?	
<input type="checkbox"/> Y <input type="checkbox"/> N Any hospitalization in the past 5 years?	_____
<input type="checkbox"/> Y <input type="checkbox"/> N Any serious illnesses/surgeries?	_____
<input type="checkbox"/> Y <input type="checkbox"/> N Use tobacco in any form? If Yes, Type:	_____
<input type="checkbox"/> Y <input type="checkbox"/> N Is pre-medication required before dental visits due to heart condition or artificial joint?	
FEMALE PATIENTS: <input type="checkbox"/> Y <input type="checkbox"/> N Currently nursing? <input type="checkbox"/> Y <input type="checkbox"/> N Currently pregnant? Due Date: _____	
Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please describe: _____	
Is there anything important about your medical condition we have not asked? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please describe: _____	

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> BULIMIA	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> PSYCHIATRIC TREATMENT
<input type="checkbox"/> ADHD	<input type="checkbox"/> CANCER/MALIGNANCY	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> RADIATION/CHEMO
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> CONVULSIONS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> STROKE
<input type="checkbox"/> ARTIFICIAL HEART VALVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> THYROID CONDITION
<input type="checkbox"/> ARTIFICIAL JOINTS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DIZZINESS/FAINTING	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> ULCERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> MONONUCLEOSIS	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> AUTISM/ASPERGER'S	<input type="checkbox"/> FREQUENT EAR INFECTIONS	<input type="checkbox"/> PACEMAKER	
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> OTHER – PLEASE LIST:	

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> CODEINE	<input type="checkbox"/> LACTOSE INTOLERANCE	<input type="checkbox"/> SLEEPING PILLS
<input type="checkbox"/> ANESTHETIC – LOCAL	<input type="checkbox"/> DAIRY	<input type="checkbox"/> METAL SENSITIVITY	<input type="checkbox"/> SULFA DRUGS
<input type="checkbox"/> BARBITURATES	<input type="checkbox"/> LATEX	<input type="checkbox"/> NITROUS OXIDE SEDATION	<input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS
<input type="checkbox"/> OTHER – PLEASE LIST			

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

<input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS	<input type="checkbox"/> ANTIHISTAMINES/ALLERGY	<input type="checkbox"/> DAILY ASPIRIN	<input type="checkbox"/> BLOOD PRESSURE MEDICATIONS
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> CANCER/CHEMO MEDICATIONS	<input type="checkbox"/> CORTISONE/STEROIDS	<input type="checkbox"/> HEART MEDICATION/DIGITALIS
<input type="checkbox"/> INSULIN	<input type="checkbox"/> NITROGLYCERIN	<input type="checkbox"/> ORAL CONTRACEPTIVES	<input type="checkbox"/> OSTEOPOROSIS MEDICATIONS
<input type="checkbox"/> RECREATIONAL DRUGS	<input type="checkbox"/> THYROID MEDICATIONS	<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> OTHER DIABETIC MEDICATIONS
<input type="checkbox"/> OTC DRUGS/ MEDICATIONS	<input type="checkbox"/> OTHER (PLEASE LIST BELOW)		

(PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____ DATE: _____

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Name:

Date:

RELATIONSHIP TO PATIENT: SELF PARENT GUARDIAN OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by South Friendswood Dental Associates:

- Cell phone: Text Message reminders permitted
 Home phone Work E-Mail:

I give permission for South Friendswood Dental Associates to disclose their identity when calling; to anyone who may answer my phone. Y N Other (Please explain)

I grant permission for South Friendswood Dental Associates to leave a message on:

- Home phone Work Phone
 Cell Phone With any person who may answer when calling the home or cell phone
 None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above: _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

NAME OF PATIENT/RESPONSIBLE PARTY (PRINT)

RELATIONSHIP TO PATIENT

DATE

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
 Communication barriers
 Emergency situation
 Other – please list:

PRIMARY INSURANCE

Person Responsible for Account _____
(Last Name) (First Name) (Middle Initial)

Relation to Patient _____ Birthdate _____ Social Security # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ ID # _____ Group # _____

ADDITIONAL INSURANCE

Secondary Subscriber _____
(Last Name) (First Name) (Middle Initial)

Relation to Patient _____ Birthdate _____ Social Security # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company(ies))

and assign directly to Dr. Sasha Mahabir &/or Dr. Rahul Gandhi 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 authorize the use of my signature on all insurance submissions. The above-named doctor(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date

SOUTH FRIENDSWOOD DENTAL ASSOCIATES
SASHA MAHABIR, DDS * RAHUL GANDHI, DMD

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