GREENWOOD
DENTAL ARTS

PATIENT INFORMATION

DATE_____

FIRST NAME _____ LAST NAME _____ BIRTHDATE _____

HOW DO YOU PREFERRED TO BE ADDRESSED _____ GENDER _____

Please list any changes to your contact information – if no changes, leave blank

ADDRESS _____

CITY/STATE/ZIP _____

CELL PHONE _____ HOME PHONE _____ WORK _____

MARITAL STATUS _____ EMAIL _____

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, your mouth is the entrance to the entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Please list your Primary Care Physician? _____ Phone: _____

Are you currently being treated for any medical condition? If yes, please explain _____

Have you ever been hospitalized or had a major operation? If yes, please explain _____

Have you ever had a serious head or neck injury? If yes, please explain _____

Please check any conditions below applicable to you.

☐ Acid Reflux/GERD	☐ Drug Addiction	☐ Leukemia
☐ AIDS/HIV Positive	☐ Easily Winded/Shortness of Breath	☐ Liver Disease
☐ Alzheimer's Disease	☐ Emphysema	☐ Low Blood Pressure
☐ Anaphylaxis	☐ Epilepsy or Seizures	☐ Lung Disease
☐ Anemia	☐ Excessive Bleeding	☐ Numbness/Tingling/Back pain
☐ Angina	☐ Excessive Thirst	☐ Osteoporosis
☐ Anxiety	☐ Fainting Spells/Dizziness	☐ Pain in Jaw Joints
☐ Arthritis/Gout	☐ Family history of Diabetes	☐ Parathyroid Disease
☐ Artificial Heart Valve	☐ Family history of Heart Disease	☐ Psychiatric Care
☐ Artificial Joint Date:_____	☐ Frequent Cough	☐ Radiation Treatments
☐ Asthma	☐ Frequent Diarrhea	☐ Recent Weight Loss
☐ Blood Disease	☐ Frequent Headaches	☐ Rheumatic Fever
☐ Blood Transfusion	☐ Glaucoma	☐ Rheumatism
☐ Breathing Problems	☐ Hay Fever/Chronic Allergies	☐ Scarlet Fever
☐ Bruise Easily	☐ Heart Attack/Failure or Arrythmia	☐ Shingles
☐ Bypass Surgery/Stint Placement	☐ Heart Pacemaker	☐ Sickle Cell Disease
☐ Cancer	☐ Heart Trouble/Disease	☐ Sinus Trouble
☐ Celiac Disease	☐ Hemophilia	☐ Sjogren's Syndrome
☐ Chemotherapy	☐ Hepatitis A	☐ Stomach/Intestinal Disease
☐ Chest Pains	☐ Hepatitis B or C	☐ Stroke
☐ Cold Sores/Fever Blisters	☐ Herpes	☐ Swelling of Limbs
☐ Congenital Heart Disorder	☐ High Blood Pressure	☐ Thyroid Disease
☐ COPD	☐ High Cholesterol	☐ Tonsilitis
☐ Cortisone Medicine	☐ Hives or Rash	☐ Tuberculosis
☐ Dementia	☐ Hypoglycemia	☐ Tumors or Growths
☐ Depression	☐ Immune system dysfunctions	☐ Ulcers
☐ Diabetes [ ] Type I [ ] Type II	☐ Irregular Heartbeat	☐ Venereal Disease
☐ Difficulty Hearing	☐ Kidney Problems	☐ Other _____

Please list any medications or supplements you are currently taking (attach list if necessary).

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ YES ☐ NO

Do you regularly monitor your blood pressure? ☐ YES ☐ NO

Do you regularly monitor your blood sugar? ☐ YES ☐ NO

Do you take medication for blood pressure or cholesterol? ☐ YES ☐ NO

Have you ever been diagnosed with prediabetes? ☐ YES ☐ NO

Do you feel that you are more than 10% above your ideal body weight? ☐ YES ☐ NO

Have you received the HPV vaccine? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO

If yes: Type of tobacco? _____

Frequency? _____

Number of years used? _____

Have you recently quit smoking or chewing tobacco or any other products? ☐ YES ☐ NO

Do you use controlled substances? ☐ YES ☐ NO

Are you allergic to any of the following?

☐ Penicillin ☐ Local Anesthetics

☐ Aspirin ☐ Sulfa drugs

☐ Latex ☐ Codeine

☐ Metal ☐ Acrylic

Other, please explain:

Women:

Are you pregnant or trying to get pregnant? ☐ YES ☐ NO

Nursing? ☐ YES ☐ NO

Taking oral contraceptives? ☐ YES ☐ NO

In case of Emergency, please contact Name: _____ ***Phone:*** _____ ***Relationship:*** _____

CONSENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my health. It is my responsibility to inform the dental office of any changes in medical status. I consent to treatment as necessary or desirable in the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include but are not limited to radiographs, models, photos, and intraoral exam. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the treatment will be explained in advance. I give my consent to the use of local anesthetics and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay them in full, at the time of service unless other arrangements are made in advance.

Signature of Patient, Parent or Guardian _____ Date _____

Office use only

Reviewed by: _____ Date _____

GREENWOOD
DENTAL ARTS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices and allow the office to share information about my treatment with the following individuals (please give specific names and phone numbers, i.e. family members, other dentists, physicians, insurance companies, attorneys, etc.):

_____ _____
_____ _____
_____ _____

Print Patient Name: _____ Relationship to patient: _____

Signature of Patient, Parent or Guardian _____ Date _____

For Office Use Only:
We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify): _____

FINANCIAL AGREEMENT

Full payment is due at the time of service and a non-refundable deposit will be required to schedule extensive treatment appointments with Dr. Alconcel, Dr. Fischer, or Dr. Johnson.
We accept Cash, Check, Visa, MasterCard, Discover, and American Express

If your insurance has changed, please provide us with updated information.

I have read, understand, and agree to the above financial agreement for payment of services provided. I understand that I am ultimately responsible for payment of all charges for services rendered to me and/or my family.

APPOINTMENT AGREEMENT

Should you need to reschedule, we kindly request that you contact us, during normal business hours, with **a minimum of 48 hours notice.** We understand that conflicts arise, however, failing your appointment or canceling without adequate notice more than once will result in a **$95 charge**.

Additionally, we do not accept appointment changes or cancellations via text or voicemail.

I have read, understand, and agree to the above financial agreement and appointment policies.

_____ _____ _____
Print Patient Name | Signature of Patient or Responsible Party | Date