First Name: ________________ Last Name:__________________ Middle Name: _____________

Date of Birth:_________________________ SS#:_____________________

Address:____ City:_________________________

State: ________ ZIP:___________ Home #___________________ Cell #: ____________________

Email: _______________________________ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed Occupation: _____________________

Name of Employer: ________________________ Phone #:_________________________________

Emergency Contact: __________________________ Phone #/Relation:_______________________

Responsible Party (If Not Self):

□ Self □ Spouse □ Father □ Mother □Guardian / Name:_____________________________________
Birth date: _____________ SS#: _______________ Address: ________________________________
City:____________________ State: __________Home or Cell #: ____________________________

Medical:

Women: Are you taking birth control? □ Yes □ No □ Are you Pregnant? □ Yes □ No □ Nursing? □ Yes □ No

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Local Anesthetics □Acrylic □Metal □Latex □Sulfa
□Other:____

Do You Smoke or Use Tobacco? □Yes □ No

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

□ AIDS/HIV Positive
□ Abnormal Bleeding
□ Alcohol Abuse
□ Alzheimer's Disease
□ Anaphylaxis
□ Anemia
□ Angina Pectoris
□ Arthritis
□ Artificial Heart Valve
□ Asthma
□ Blood Transfusion
□ Cancer If Yes, Type_______________When______________
□ Chemotherapy/Bisphosphonates
□ Colitis
□ Congenital Heart Defect
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Facial Surgery
□ Fainting Spells
□ Fever Blisters
□ Frequent Headaches
□ Glaucoma
□ Heart Attack
□ Heart Murmur

□ Artificial Joint ___________________ Date of Surgery_____________
Antibiotic Taken?___________________
Antibiotic Directions:____

□ Heart Surgery
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ High Blood Pressure
□ Sinus Problems
□ Tuberculosis
□ Kidney Problems
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Shingles
□ Psychiatric Problems
□ Stroke
□ Ulcers
□ Radiation Therapy
□ Rheumatic Fever
□ Seizures
□ Sexually Transmitted Disease
□ Sickle Cell Disease
□Thyroid Problems
□ Pacemaker

Any Other Medical Conditions Not Listed Here:

____

Have you ever taken Fosamax, Boniva, Actonel, or any bisphosphonates? □**YES** □**NO**

Medications:

Please list ALL prescription and over-the-counter medications, plus the reasons for taking them.

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Authorization to Release Information to Family Members:

I authorize Bircher Family Dental Care to release my records and any information to the following individuals: (Name, Relation to Patient, Phone Number)

1.______________________________ ______________ __________________

2.______________________________ ______________ __________________

3.______________________________ ______________ __________________

Treatment Authorization:

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding any medical condition.

Dental Insurance Assignment and Release:

I, the undersigned have dental coverage. I assign directly to BIRCHER FAMILY DENTAL CARE 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 the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Financial Agreement:

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of minor/child. I accept full financial responsibility for all charges not covered by insurance, including missed appointment charges. I am aware that any unpaid balance will be turned over to a third party collector and an additional service fee may be added. Returned checks will result in a $25 fee and replacement of funds must be paid by cash or credit card.

I attest that all of the above information is accurate and true and agree to the stated terms.

________________________________ __________

Signature Date

****

Acknowledgement of Receipt/Notice of Privacy Practices (HIPAA):

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice**.** I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice. I also understand that I have the right to not sign this acknowledgement.

_____________________________ ____________________ ________

Name Printed / **Circle On**e: Self / Guardian Signature Date

____ ________

Witness/Signature Date