Welcome!
Adult New Patient Form

Crystal Lee, DDS

Patient Information

Date _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Title Mr. Mrs. Ms. Dr. Other _____ I Prefer to be Called _____

Birth Date _____ Sex: Male Female

Home address _____

City, State, Zip Code _____

Home Phone ( ) _____-_____ Cell Phone ( )_____-_____

Email Address(es)

_____

Occupation _____ Employer _____

Are you okay with text reminders? Y N Are you okay with e-mail reminders? Y N

Emergency Contact

Emergency Contact _____ Relationship _____

Address (if different from patient address) _____

Cell phone ( ) _____-_____

Dental Insurance

Primary Policy Holder's Full Name _____ Birth date _____

Social Security # or Policy # _____ Relationship to Patient _____

Address and Phone # (if different from patient)_____

Employer _____ Address _____

Insurance company _____ Group # _____

Secondary Policy holder's Full name _____Birth date _____

Social Security # or Policy # _____ Relationship to Patient _____

Address and Phone # (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____

Dentist

Previous Dentist _____

Last Seen _____ Reason _____

Physician

Patient's Physician _____ City, State _____

Last seen _____ Reason _____

Most recent physical exam date_____

General Information

Have you been hospitalized or been treated for a serious illness in the last three years?

_____

Do you have any children who have been treated in this office? Please name them.

_____

What concerns you about your teeth?

_____

Medical History

Do you take antibiotic pre-medication before any dental procedures? _____

List any medication(s) that you take

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? If yes, please list them

_____

Do you chew or smoke tobacco? If yes, please specify frequency _____

Are you pregnant or nursing? Y N Are you planning to become pregnant? Y N

Are you taking Birth Control? Y N

Please mark if you **have or have had** any of the conditions below:

___ Allergies (Medication, latex, food)
_____
___ Anxiety
___ Anemia
___ Arthritis, Rheumatism, Other Joint Related Pain
___ Artificial Joint / Hip
___ Asthma
___ Blood Related Disease
___ Blood Transfusion
___ Cancer, Tumor
___ Chemotherapy
___ Diabetes
___ Dizziness / Fainting
___ Epilepsy / Seizures
___ Excessive Bleeding
___ Fever
___ Head / Neck Injuries
___ Heart Defect/ Artificial Heart Valves, Heart Murmur, Other Heart Related Disease
___ Hepatitis
___ High Blood Pressure
___ Immune Deficiency
___ Kidney Disease
___ Liver Disease
___ Psychiatric Care
___ Pacemaker
___ Radiation Treatment
___ Respiratory Problems
___ Sexually Transmitted Disease
___ Stomach Problems, Ulcers
___ Stroke
___ Thyroid, Adrenal Disease
___ Tuberculosis
___ Surgeries
_____
_____
___ Other
_____
_____

If you have or have had any other disease or medical condition **NOT** listed on this form, please explain:

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and / or medications.

_____

Patient Signature

_____

Date

HIPAA Privacy Act
Acknowledgement of Receipt
of
Notice of Privacy Practices

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of ***Pediatric Dentistry of San Clemente*** (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have received the Policy and understand its terms and conditions.

OR

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the policy. I understand that even though I may refuse to sign this acknowledgement, the Dentist may still provide treatment to me.

_____
Patient Name

_____
Signature of Patient or Legal Representiative

_____
Date