JAMES B. FOLEY, D.D.S.

Aesthetic Dentistry

Patient Information (Confidential) **Date**_____

Name_____ Birthdate_____ Sex_____F _____M

Address_____

Email Address_____SS#_____

Phone: Cell_____ Home_____Work_____

Contact Preferences: _____Cell_____Home_____Work_____Email_____SS#_____

_____ Minor _____Single _____Married _____Divorced _____Widowed _____Separated

If Student, Name of School or College_____ City_____State_____FT____PT___

Patient or Patient Guardian's Employer_____Work Phone_____

Business Address_____

Spouse or Parent/Guardian's Name_____Employer_____Work Phone_____

Emergency Contact Name_____Phone_____

How did you hear about us? _____Google _____Website _____Friend _____Coworker _____Other

Responsible Party Check _____If same as patient. If insured, move on to insurance information,
If not insured, skip insurance information

Name of person responsible for this account_____Relationship to the Patient_____

Is Responsible Party currently a Patient in our Office? If yes, skip this section unless Insurance has changed.

Address if different than patient_____Best contact phone_____

Email_____Driver's License #_____Birth Date_____

Employer_____ Work Phone_____SS#_____

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Insurance Information

If you have insurance, Please present card(s) on your visit

Name of Insured_____Relationship to Patient_____Birthdate_____

SS#_____Date Employed_____Name of Employer_____

Address of Employer_____

Insurance Company_____ID#_____Group#_____

Address_____

Patient Dental History

Name of previous Dentist and Location_____Date of Last Dental Exam_____

Do your gums bleed while brushing or flossing? Y_____ N_____
Are your teeth sensitive to hot or cold liquids or foods? Y_____ N_____
Are your teeth sensitive to sweet or sour liquids or foods? Y_____ N_____
Do you feel any pain to any of your teeth? Y_____ N_____
Do you have any sores or lumps in or near your mouth? Y_____ N_____
Have you had any head, neck or jaw injuries? Y_____ N_____
Do you have frequent headaches? Y_____ N_____
Do you clench or grind your teeth? Y_____ N_____
Do you bite your lips or cheeks frequently? Y_____ N_____
Have you ever had any difficult extractions in the past? Y_____ N_____
Have you had any orthodontic treatment? Y_____ N_____
Do you wear dentures or partials? Y_____ N_____
If Yes, date of placement_____
Have you ever received oral hygiene instructions? Y_____ N_____

Have you ever experienced any of the following problems in your jaw?

Clicking Y_____ N_____
Pain (joint, ear, side of face) Y_____ N_____
Difficulty in opening or closing Y_____ N_____
Difficulty in chewing Y_____ N_____

What would you like to change about your smile?

_____

_____

JAMES FOLEY MEDICAL HISTORY

Patient Name: Birth Date: Date Created

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body.

Are you under a physician's care now?	○ Yes	○ No	If Yes
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If Yes
Have you ever had a serious head or neck injury?	○ Yes	○ No	If Yes
Are you taking any medications, pills or drugs?	○ Yes	○ No	If Yes
Do you take, or have you taken Phen-Pen or Redux?	○ Yes	○ No	If Yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	If Yes
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	If Yes

Women, are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of he following?..

☐ Aspirin ☐ Penecillin ☐ Codeine ☐ Acryllic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? If Yes

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

AIDS/HIV Positive	○ Yes	○ No	Cortisone Medicine	○ Yes	○ No	Hemophilia	○ Yes	○ No	Radiation Treatments	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Diabetes	○ Yes	○ No	Hepatitis-A	○ Yes	○ No	Recent Weight Loss	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Drug Addiction	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Anemia	○ Yes	○ No	Easily Winded	○ Yes	○ No	Herpes	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No
Angina	○ Yes	○ No	Emphysema	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Rheumatism	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	Epilepsy or Seizures	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Scarlet Fever	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Excessive bleeding	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Shingles	○ Yes	○ No
Artificial Joint	○ Yes	○ No	Excessive Thirst	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Asthma	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
Blood Disease	○ Yes	○ No	Frequent Cough	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Spina Bifida	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Frequent Diarrhea	○ Yes	○ No	Leukemia	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes	○ No
Breathing Problems	○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Liver Disease	○ Yes	○ No	Stroke	○ Yes	○ No
Bruise Easily	○ Yes	○ No	Genital Herpes	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Swelling of Limbs	○ Yes	○ No
Cancer	○ Yes	○ No	Glaucoma	○ Yes	○ No	Lung Disease	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Hay Fever	○ Yes	○ No	Mitral valve Prolapse	○ Yes	○ No	Tonsilitis	○ Yes	○ No
Chest Pains	○ Yes	○ No	Heart Attack/Failure	○ Yes	○ No	Osteoporosis	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Cold Sores/Fever Blisters	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Pain in Jaw Joints	○ Yes	○ No	Tumors or Growths	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No	Parathyroid Disease	○ Yes	○ No	Ulcers	○ Yes	○ No
Convulsions	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No	Psychiatric Care	○ Yes	○ No	Venereal Diseases	○ Yes	○ No
									Yellow Jaundice	○ Yes	○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If Yes

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient, Parent or Guardian:

X_____ Date:_____

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Authorization & Release
Financial Policy

Payment is due at the time of treatment unless prior arrangements have been approved

This office accepts insurance, with which we are contracted. I understand that I am responsible for payment of services rendered and also responsible for paying any co-pay and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. For insurances with which we are not contracted, payment in full will be expected, and your insurance company will reimburse you for benefits according to your insurance plan. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature of patient (or parent/guardian) **Date**

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ACKNKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy practice documents our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this offices' Notice of Privacy Practice.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

AUTHORIZATION TO RELEASE INFORMATION

Pupose: This form is used to obtain authorization to release information regarding yourself covered by the Privacy Act to people other than yourself

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)

_____ _____
(Please Print Name) (Relationship)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,but acknowledgement could not obtained.

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify) _____

_____