PATIENT INFORMATION

Date:_____ Social Security #:_____ Birthdate:_____

Name**:** _____
Last First MI

Address**:**_____
Street City State Zip

Phone #s: (Home)_____ (Cell)_____ (Work)_____

Email Address:_____ Sex: ____Male ____Female

Child_____ Single_____ Married_____ Divorced_____ Widowed _____ Other_____

Who should we thank for referring you?_____

In case of emergency, who should we contact_____
Name Phone #

MEDICAL HISTORY

Current Dentist Name:_____ Physician's Name:_____

	YES	NO
1. Are you currently under medical treatment?	____	____
2. Have you ever had any serious illnesses or operations?	____	____
3. Are you currently taking any medications?	____	____
4. Do you smoke?	____	____
5. Do you use alcohol, cocaine or other drugs?	____	____
6. Do you wear contact lenses?	____	____
7. Are you taking or have you ever been treated with any Bisphosphonate drugs?	____	____
Didronel	____	____
Bonefos/Loron	____	____
Skelid	____	____
Aredia	____	____
Fosamax	____	____
Boniva	____	____
Actonel	____	____
Zometa	____	____
Reclast (IV)	____	____

8. Have you had any allergic reactions to the following?	YES	NO
Local Anesthetics (eg. Novocaine)	____	____
Penicillin or other Antibiotics	____	____
Sulfa Drugs	____	____
Barbiturates (sleeping pills)	____	____
Sedatives	____	____
Iodine	____	____
Aspirin	____	____
Latex	____	____
Other	____	____
9. **WOMEN ONLY**		
Pregnant?	____	____
Nursing?	____	____
Taking birth control pills?	____	____

Please check all that apply:

Aids	____	Emphysema	____	Pacemaker	____
Anemia	____	Epilepsy	____	Psychiatric Care	____
Arthritis, Rheumatism	____	Fainting or Dizziness	____	Radiation Treatment	____
Artificial Heart Valves	____	Glaucoma	____	Respiratory Disease	____
Asthma	____	Headaches	____	Rheumatic Fever	____
Back Problems	____	Heart Murmur	____	Scarlet Fever	____
Bleeding abnormally with extractions or surgery	____	Heart Problems	____	Shortness of Breath	____
		Hepatitis-Type____	____	Sinus Trouble	____
Blood Disease	____	Herpes/Venereal Disease	____	Skin Rash	____
Cancer	____	High Blood Pressure	____	Stroke	____
Chemical Dependency	____	HIV Positive	____	Swelling of feet/ankles	____
Chemotherapy	____	Jaundice	____	Swollen Neck Glands	____
Chronic Fatigue Syndrome	____	Jaw Pain	____	Thyroid Problems	____
Circulatory Problems	____	Kidney Disease	____	Tonsillitis	____
Congenital Heart Lesions	____	Liver Disease	____	Tuberculosis	____
Cortisone Treatments	____	Low Blood Pressure	____	Tumor or growth on head/neck	____
Cough-persistent or bloody	____	Mitral Valve Prolapse	____	Ulcer	____
Diabetes	____	Nervous Disorders	____		

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Employment Information

Employer Name:_____Occupation:_____

Address:_____

Street City State Zip Code

Insurance Information

Primary (Dental)

Name of Insured:_____

Last First MI

Insured's Birth Date:_____ SS#:_____ Group #:_____

Insured's Address:_____

Street City State Zip Code

Patient's relationship to insured: ____Self _____Spouse _____Child _____Other_____

Insurance Plan Name and Address:_____

_____

Secondary (Medical)

Name of Insured: _____

Last First MI

Insured's Birth Date:_____ SS#:_____ Group#:_____

Insured's Address:_____

Patient's relationship to insured: _____Self _____Spouse _____Child _____Other_____

Insurance Plan Name and Address:_____

_____

Consent for Services

I hereby authorize payment directly to Rafael Alcalde, DDS, PA for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____

HIPAA ~ ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name:_____ Patient Date of Birth:_____

We at Rafael Alcalde, DDS, PA are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____ _____

Printed name of patient or patient's representative/parent Relationship to patient

May we leave a message regarding an upcoming appointment:

Answering machine at home or cell phone?	_____Yes _____No
Office Voice mail?	_____Yes _____No
With another person?	_____Yes _____No
Send through email?	_____Yes _____No

May we leave other medical information on:

Answering machine at home or cell phone?	_____Yes _____No
Office voice mail?	_____Yes _____No
With another person?	_____Yes _____No
Send through email?	_____Yes _____No

Person(s) authorized to discuss above?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

*****DUE TO THE PRIVACY OF OUR PATIENTS AS WELL AS THE STAFF, NO PHOTOS OR VIDEOS WILL BE ALLOWED WHILE THE PATIENT IS IN THE OFFICE.

_____ _____

Signature of patient or patient's representative/parent Date

_____ _____

Printed name of patient or patient's representative/parent Relationship to patient