Caledonia Family Dentistry
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3352 Brown Rd.
Caledonia, NY 14423

I understand that, under the Health Insurance Portablility & Accountablility Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

~Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
~Obtain payment from third-party payers (dental insurance)
~Conduct normal healthcare operations such as send appointment reminders, make reminder phone calls, scheduling appointments

I acknowledge that I have the right to receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
(please print)
Relationship to Patient (if minor):_____

Signature: _____

Date: _____

If you would like other family members to have access to your dental information, please include those names below:

_____ (relationship to Patient)_____

_____ (relationship to Patient)_____

_____ (relationship to Patient)_____

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____

Business Address _____ Business Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Arthritis	☐ Headaches	☐ Psychiatric Care
☐ Artificial Heart Valves or Joints, Screws, etc	☐ Heart Murmur	☐ Radiation Treatment
☐ Back Problems	☐ Heart Problems	☐ Recent Weight Loss
☐ Bleeding Abnormally	☐ Hemophilia	☐ Respiratory Disease
☐ Blood Disease	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Cancer	☐ Hernia Repair	☐ Sinus Problems
☐ Chemical Dependency	☐ High Blood Pressure	☐ Special Diet
☐ Chronic Diarrhea	☐ HIV/AIDS	☐ Stroke
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Diabetes	☐ Nervous Problems	☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time?_____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative _____ Date _____

Please print name of Parent, Guardian or Personal Representative _____ Relationship to Patient _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

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Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature _____

Date _____ Dentist Signature _____