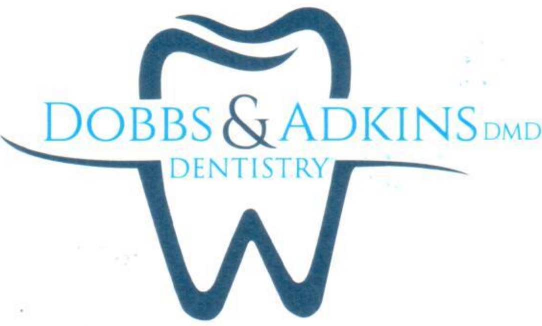



# Welcome

## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

**Date** ________________

## Patient Information (Confidential)

Name ______________ Home Phone ______________ Cell Phone ______________

Soc. Sec # (Required) ______________ Birthdate ______________ Email ______________

Address ______________ City ______________ State ________ Zip ________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College ______________ City ______________ State ________ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer ______________ Work Phone ______________

Business Address ______________ City ______________ State ________ Zip ________

Spouse or Parent's Name ______________ Employer ______________ Work Phone ______________

Whom May We Thank for Referring You? ______________

Person to Contact in Case of Emergency ______________ Phone ______________

## Responsible Party

Name of Person Responsible for this Account ______________ Relationship to Patient ______________

Address ______________ Home Phone ______________

Drivers License # ______________ Birthdate ______________

Employer ______________ Work Phone ______________ SSN# ______________

Is this Person Currently a Patient in out Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ Master Card

## Primary Insurance Information

Name of Insured ______________ Relationship to Patient ______________

Birthdate ________ Social Security # ______________ Date Insurance Effective ______________

Name of Employer ______________ Work Phone ______________

Employer Address ______________ City ______________ State ________ Zip ________

Insurance Company ______________ Group # ______________ Policy/ID# ______________

Ins. Co. Address ______________ City ______________ State ________ Zip ________

How Much is Your Deductible? ______________

**Do You Have Any Additional Insurance?** ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured ______________ Relationship to Patient ______________

Birthdate ________ Social Security # ______________ Date Insurance Effective ______________

Name of Employer ______________ Work Phone ______________

Employer Address ______________ City ______________ State ________ Zip ________

Insurance Company ______________ Group # ______________ Policy/ID# ______________

Ins. Co. Address ______________ City ______________ State ________ Zip ________

How Much is Your Deductible? ______________

**Over Please**

# Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ |

If yes, please explain ______________________

| | Yes | No |
|---|---|---|
| 3. Are you taking any medication(s) including non-prescription medicine or herbal supplements? | ☐ | ☐ |

If yes, please list ______________________

| | Yes | No |
|---|---|---|
| 4. Do you take blood thinners? | ☐ | ☐ |
| 5. Have you ever taken Phen-Fen/Redux? | ☐ | ☐ |
| 6. Do you use tobacco | ☐ | ☐ |
| 7. Do you use controlled substances? | ☐ | ☐ |

8. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Stomach Troubles/Ulcers | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ | Angina | ☐ | ☐ | Stroke | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Hepatitis B | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Hepatitis C | ☐ | ☐ | Other ______________ | ☐ | ☐ |

9. Are you allergic to or have you had any reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. Novocaine) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other, please list ______________________ | ☐ | ☐ |

10. Women Only:

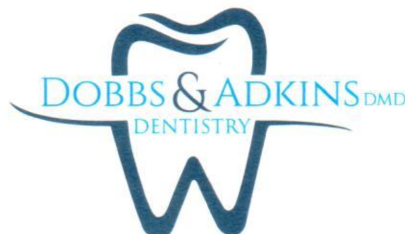
| | Yes | No |
|---|---|---|
| Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records to any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Any unpaid account may be placed with an attorney for collection. In this event the person responsible for the patient's account agrees to pay an attorney's fee, court cost & other reasonable cost of collection. Signature below gives consent for treatment.

**X** ______________________________________________

Signature of responsible party Date



# David Dobbs, D.M.D., L.L.C.
# Michael Adkins, D.M.D., L.L.C.

**417 Main Street**
**Trussville, AL 35173**

## Notice of Privacy Practices Acknowledgement Form

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below.

## Patients Rights

As a patient you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information ( PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e. "only communicate with me at my work number").

## Provider Rights

As your health care provider, we can use or disclose your PHI for treatment, payment or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

________________________________ __________________________

Patient Signature or Legal Guardian Date of Signature

________________________________ __________________________

Patient Name ( Printed) Date of Birth