CENTRAL PARK DENTISTRY
PERSONAL INFORMATION

Last Name First Middle

☐ Single
☐ Married
☐ Widow

Date of Birth Age

Street Address

Home Phone Work Phone

City State Zip

Social Security Number Cell Phone

Mailing address (if different from above)

Previous dentist Last visit

Person responsible for acct. Relationship

Employer Occupation

In case of Emerg. Contact - Name and Number

Dental Insurance Information:

Employer _____

Insurance Company Name _____

Social Security Number of Employee _____

Employee Name _____

Employee Date of Birth _____

Referred by

E-mail address

Consent for Treatment:

I hereby grant authority to Dr. Lala, Dr. Hansen, and/or Dr. Thackery to administer any treatment; and to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of me. I understand that I will be consulted before any treatment is rendered.

(Patient or Parent of Minor Date

Our Office Policy:

To enable us to establish the best relationship possible with our patients from the very beginning and to avoid misunderstandings in the future, we have established certain office policies. Please read these pollicies and sign below signifying you have read and understand our policies.

Each patient we treat is entitled to, and will receive, a thorough and careful examination. We are dedicated to the principle of doing our best in treating all patients with the highest quality therapy possible.

It is our office policy that **24 Hours Notice must be given** if you are forced to cancel an appointment. We do not charge for "broken appointments" (no-shows and last minute cancellations.) However, after two broken appointments, we will give your file an "inactive status" and special arrangements must be made to reactivate it. Our purpose in establishing this policy is to avoid making patients wait long periods of time for an appointment. If we are given proper notice of a cancellation, it enables other patients who are waiting for treatment to be called.

Parents need not accompany their children to the treatment room. Children are usually more cooperative when their parent is not in the same room. We will examine your child and determine what he/she needs and then the doctor will discuss this with you before treatment begins.

Signature – Patient or Parent of Minor

Payment Policy:

It is customary to pay for dental services in full when treatment is rendered. We accept cash, check, Visa, and MasterCard. We do file dental insurance, but any deductibles and co-insurance are due at the time services are rendered. If at any time financial arrangements need to be discussed, we ask that you contact our office coordinator prior to the appointment.

Signature, Patient or Parent of Minor

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:
_____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:
_____

Have you ever had a serious head or neck injury? Yes No If yes, please explain:
_____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain:
_____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you need to pre-medicate? Yes No If yes, please explain:
_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No
Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain:
_____
_____
_____

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 _____ DATE _____

Central Park Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I acknowledge that I have received a copy of this office's HIPPA Notice of Privacy Practices.

_____

{Please Print Name}

_____

{Signature} {Date}

OR

_____

{Signature of Representative/Guardian}

Authority of Representative/Guardian to Sign for Patient (check one):

❑Parent ❑Guardian ❑Power of Attorney ❑Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

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

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

Central Park Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Central Park Dentistry cumple con las leyes federales de derechos civiles y no discrimina por raza, color, origen nacional, edad, discapacidad o sexo.