Patient Information

Patient Name: ____Preferred Name:__________________
Last First Middle

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other________________

Social Security #: ________________________________ Date of Birth________________________________

Phone (Home): _________________ (Work): ________________ Ext:______ (Cell):_____________________

Address: ____
Street Apartment #
____
City State Zip Code

Please include your email address if you would like us to send appointment reminders there:___________________________

Who may we thank for referring you to our office? ____

Health Information

Have you ever had any of the following? Please check those that apply:

MEDICAL HISTORY
- ☐ AIDS/HIV
- ☐ Allergies __________ ______________________ ________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy Date:___________
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths / Tumors
- ☐ Head Injuries
- ☐ Hearing Impaired
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

DRUG ALLERGIES
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other:______________ ___________________

Women

☐ Are you nursing?
Are you pregnant?
Due date:_________

DENTAL HISTORY

Date of last Dental visit ___________________

Reason for your visit today_________________ ______________________ ______________

- ☐ Bad Breath
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clench/ Grind teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold, heat or sweets
- ☐ Wisdom teeth removed

How often do you floss? ___________________

How often do you brush? ___________________

List all medications you are currently taking____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ____ Phone: ___________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

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 doctors at the next appointment without fail.

____ Date:_____________________
Signature of patient, parent or guardian

Responsible Party Information

The following information is for:
☐ patient's spouse ☐ person responsible for payment Relationship to patient____________________

Name: ____________________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ________________ Ext:__________ (Cell): ________________

Address: ____________________
Street Apartment #
____
City State Zip Code

Employment Information

The following information is for: ☐ patient ☐ person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ____________________
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ____________________ ____________________ __________
Last First M

Insured's Birth Date: ________________ ID #: ____________________ Group #:____________________

Insured's Address: ____________________
Street City State Zip Code

Insured's Employer Name: ____________________

Address: ____________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Insurance Plan Name and Address: ____________________
____

Secondary

Name of Insured: ____________________ ____________________ __________
Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #:____________________

Insured's Address: ____________________
Street City State Zip Code

Insured's Employer Name: ____________________

Address: ____________________
Street City State Zip Code

Patient's relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Insurance Plan Name and Address: ____________________
____

Cool Creek Dentistry, PC

2458 E. 146th St.
Carmel, IN 46033

DUE TO THE HIPAA PRIVACY ACT IT IS REQUIRED THAT WE HAVE IN YOUR CHART A SIGNED AND DATED FORM STATING:

HOW MAY WE CONTACT YOU?

(PLEASE CHECK ALL THAT APPLY)

_____MAIL
_____PHONE
_____VOICE MAIL
_____ANSWERING MACHINE

Checking the above gives us permission to call you, leave messages, etc. This also allows the doctor or his representative to discuss treatment over the phone or via mail. We will not leave messages regarding your treatment without your permission. Please check here ____ if we have the permission to do so.

TO WHOM MAY WE GIVE INFORMATION TO REGARDING YOUR CARE?

(PLEASE LIST THOSE WHOM WE MAY TALK OR RELEASE RECORDS TO – ie. A SPOUSE, SIGNIFICANT OTHER, PARENT, FAMILY DOCTOR, REFERRING DOCTOR, ETC.)

NAME____
RELATIONSHIP______________________PHONE______________

NAME____
RELATIONSHIP______________________PHONE______________

NAME____
RELATIONSHIP______________________PHONE______________

NAME____
RELATIONSHIP______________________PHONE______________

PATIENT SIGNATURE (OR GUARDIAN)__________________________
PRINT NAME______________________________
DATE____________