# Gosport Dental Clinic
## Dr. Lamere-Heck

10 E. Main St
Gosport, IN 47433

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facebook.com/gosport-dental 812-879-4216

## Patient Information

Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Do you prefer Text or Email Appointment Confirmations? _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? (Name & Phone #) _____

When was your last Dental Visit? _____

## Insurance Information

Insurance Subscriber (who carries the policy) _____ DOB: _____

Insurance Company Name: _____ Phone # (on back of card) _____

Employer: _____ Member/Subscriber ID# _____

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date _____

# Patient Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

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, c

| | | |
|---|---|---|
| Are you under a physician's care now? | ◯ Yes ◯ No | If yes |
| Have you ever been hospitalized or had a major operation? | ◯ Yes ◯ No | If yes |
| Do you require Pre-Medication prior to dental treatment? | ◯ Yes ◯ No | |
| Are you taking any medications, pills, or drugs? | ◯ Yes ◯ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ◯ Yes ◯ No | If yes |
| Are you currently on a pain contract? | ◯ Yes ◯ No | If yes |
| Do you use tobacco? | ◯ Yes ◯ No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Plain Anesthetic

| | | |
|---|---|---|
| Do you use controlled substances? | ◯ Yes ◯ No | If yes |
| Other? | ☐ | If yes |

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

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Positive | ◯ Yes ◯ No | Alzheimer's Disease | ◯ Yes ◯ No | Anemia | ◯ Yes ◯ No |
| Arthritis/Gout/Rheumatism | ◯ Yes ◯ No | Artificial Heart Valve | ◯ Yes ◯ No | Artificial Joint | ◯ Yes ◯ No |
| Asthma | ◯ Yes ◯ No | Blood Disease | ◯ Yes ◯ No | Blood Transfusion | ◯ Yes ◯ No |
| Breathing Problems | ◯ Yes ◯ No | Bruise Easily | ◯ Yes ◯ No | Cancer | ◯ Yes ◯ No |
| Chemotherapy or Radiation | ◯ Yes ◯ No | Chest Pains or Angina | ◯ Yes ◯ No | Cold Sores/Fever Blisters | ◯ Yes ◯ No |
| Congenital Heart Disorder | ◯ Yes ◯ No | Diabetes | ◯ Yes ◯ No | Drug Addiction | ◯ Yes ◯ No |
| Epilepsy or Seizures | ◯ Yes ◯ No | Excessive Bleeding | ◯ Yes ◯ No | Fainting Spells/Dizziness | ◯ Yes ◯ No |
| Frequent Cough | ◯ Yes ◯ No | Frequent Headaches | ◯ Yes ◯ No | Heart Attack/Failure | ◯ Yes ◯ No |
| Heart Defibrillator | ◯ Yes ◯ No | Heart Pacemaker | ◯ Yes ◯ No | Heart Trouble/Disease | ◯ Yes ◯ No |
| Hepatitis A, B, or C | ◯ Yes ◯ No | Herpes | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No |
| High Cholesterol | ◯ Yes ◯ No | Irregular Heartbeat | ◯ Yes ◯ No | Kidney Problems | ◯ Yes ◯ No |
| Liver Disease | ◯ Yes ◯ No | Low Blood Pressure | ◯ Yes ◯ No | Lung Disease | ◯ Yes ◯ No |
| Mitral Valve Prolapse | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No | Pain in Jaw Joints | ◯ Yes ◯ No |
| Psychiatric Care | ◯ Yes ◯ No | Sickle Cell Disease | ◯ Yes ◯ No | Sinus Trouble | ◯ Yes ◯ No |
| STD | ◯ Yes ◯ No | Stomach/Intestinal Disease | ◯ Yes ◯ No | Stroke | ◯ Yes ◯ No |
| Thyroid Disease | ◯ Yes ◯ No | | | | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X

Date:_____

## CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,_____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- ○ Sensitive Protected Health Information (HIV- related information)
- ○ You may disclose information to my family members and/or non-family members

**Please list the name, phone number and relationship**

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

_____

_____

- ○ You may leave Protected Health Information on my answering machine/voicemail: Phone Number_____
- ○ You may leave me a text message: Text Phone Number_____
- ○ You may email me (unencrypted) for dental appointments: Email Address:_____
- ○ You may fax me for dental information: Fax Number_____
- ○ Other_____

**I have received a copy of this office's Notice of Privacy Practices.**

Print Name:_____

Signature:_____

(Patient's Signature (or Guardian, if minor)

Date:_____

### 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
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)