Lana B. Atchley, D.M.D.
Family & Cosmetic Dentistry

Date _____

About You:

Name _____ I prefer to be called _____

Birthdate _____ Age _____ Social Security # _____ Male _____ Female _____

Address_____

Home phone _____ Wireless phone _____ Work phone _____

E-mail address _____ Driver's license # _____

Employer _____ Whom may we thank for referring you? _____

Spouse or person responsible for account other than yourself_____

Relation _____ Social Security # _____ Phone _____ Employer _____

Medical History:

Do you require antibiotics before dental treatment? _____

Are you allergic to any medicine? _____ ***If so, what?***_____

Do you have?

__Abnormal Bleeding	__Hepatitis
__Artificial Joints/Bones	__Lung Disease/Asthma
__Artificial Heart Valves	__Kidney/Liver Disease
__Cancer/Radiation Tx	__Seizures
__High Blood Pressure	__Thyroid problems
__Diabetes	__Glaucoma
__HIV+/AIDS	__Latex Allergy
__Heart Disease/Surgery	__Pregnant/Nursing
__Reflux/Stomach problems	__Herpes

Are you taking any of the following?

Blood Thinners/Aspirin _____

Blood Pressure Medicine _____

Bisphosphonates (Fosamax, Boniva) _____

Insulin/Diabetes Drugs_____

Recreational/Street Drugs/ History of abuse? _____

Statins/Cholesterol medicine _____

Thyroid Medicine _____

List any other medicines _____

_____

Significant present/past medical problems not listed above:_____

_____

Are you currently under the care of a physician?_____

Physician's name and phone number _____

Dental History: Why have you come to the dentist today_____

Do your gums bleed?_____

Have you had periodontal (gum)treatment? _____

Do you have TMJ problems? _____

Do you hear clicking/popping when you chew? _____

Do you have morning headaches? _____

Does your jaw ever lock open/closed? _____

Do you use tobacco in any form? _____

Dental Insurance Information:

Insurance Company Name _____ Employer_____

Insured's Name (if not self) _____Relation _____

Insured's Social Security # _____ Insured's Birthdate _____

Insured's Employer _____

Authorizations:

I certify that I am covered by _____ insurance company and I assign payment directly to Dr. Atchley for services rendered. I am responsible for paying all co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

The privacy policy of this office has been made available to me. (Initial) _____

If unable to keep your appointment, kindly give a 24 hour notice, otherwise a charge will be made for time reserved. (initial) _____

Signature _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE.

Notes: