Angel Smiles Dental PC
www.angelsmilesdental.com
info@angelsmilesdental.com
8159 East 109th Avenue • Crown Point, IN 46307 (219)663-6077

Patient Information

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Date of Birth _____ SS# _____

Gender: Male _____ Female _____ Status: Married _____ Single _____ Child _____ Other _____

Address _____

City _____ State_____ Zip _____

Home _____ Cell _____ Work _____

Email _____

Employer/Occupation_____

Whom may we thank for referring you? _____

Emergency Contact

Name _____ Phone_____ Relationship_____

Insurance Information

Insurance Company_____ Phone_____

ID # _____ Group # _____

Policy Holder_____ Date of Birth_____

SS#_____ Relationship to Patient_____

Please check any of the following which apply to you now or in the past:

- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy-Ibuprofen
- ☐ Allergy-Metal
- ☐ Anemia/Excess Bleed
- ☐ Angina
- ☐ Art. Joints/Implants
- ☐ Arthritis
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Clench/Grind Teeth
- ☐ Dental Sensitivity
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Depend
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Freq. Dry Mouth
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Head Injuries
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ Heartburn
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Implants
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Nervous Disorders
- ☐ Nursing (Currently)
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy(Currently)
- ☐ Psychiatric Disorder
- ☐ Radiation Treatment
- ☐ Recent Hospitalization
- ☐ Recreational Drugs
- ☐ Reflux
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Serious Illness
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco/Vape Use
- ☐ Tumors
- ☐ Ulcers

Are you currently pregnant?_____ If yes, when are you expecting_____

Are you currently nursing?_____

Primary Physician's Name/Phone Number_____

Pharmacy/ Phone/ Address_____

Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, aspirin, latex, or metals? If yes, please explain

_____

_____

Have you seen a physician or been hospitalized in the past year (inlcuding pregnancy)? If yes, please explain

_____

_____

Are you taking or have you ever taken any medication to treat Osteoporosis (Fosamax, Reclast, etc.)?

_____

_____

Please list prescription and over the counter drugs, medications, vitamins, or herbs you are taking at this time:

_____

_____

_____

Signature

_____

Response Date: _____

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Request For Confidential Communications

Home # _____ **May we leave a message?** ○ Yes ○ No

Work # _____ **May we leave a message?** ○ Yes ○ No

Cell # _____ **May we leave a message?** ○ Yes ○ No

May we send a text message? ○ Yes ○ No

Email _____ **May we send an email?** ○ Yes ○ No

HIPAA Compliance Statement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1. Conduct, plan, and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third party payers. 3. Conduct normal health care operations such as quality assessments and physicians certifications.

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Informed Consent for Dental Treatment

I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy. I understand that antibiotics, analgesics "Pain medicines", anesthetics, latex, and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting, and/or more severe allergic reactions.

I authorize my dentist UPON INFORMING me to make changes and/or additions to my treatment plan as necessary. I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examinations. Some of these changes are, but are not limited to, root canal therapy that is necessary following the placement of "deep fillings" or crowns recommended after placement of "large fillings".

I understand that the treatment my dentist recommends is based on what he determines is best for my dental health. I understand that my insurance (if any) may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered. I acknowledge that I am responsible for any balance accrued on my account.

Patient Name(Print) _____DOB_____ Relationship to Patient _____

Signature:

Response Date: _____