

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate. Your email will not be shared and will be used for the sole purpose of communication with us. We may ask for copies of your driver's license and insurance card.

**CONTACT INFORMATION**

NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ DOB \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_ SS # \_\_\_\_\_ SEX M  F

ADDRESS PHYSICAL \_\_\_\_\_  
MAILING \_\_\_\_\_

PHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

EMAIL \_\_\_\_\_ BEST WAY TO CONTACT YOU? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DO YOU HAVE DENTAL INSURANCE? YES  NO

**IF PATIENT IS A MINOR**

MOTHER \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

FATHER \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**DENTAL INFORMATION**

DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS?	Y	N	DO YOU HAVE SORES OR ULCERS IN YOUR MOUTH?	Y	N
ARE YOUR TEETH SENSITIVE TO HOT, SWEETS, COLD?	Y	N	DO YOU GRIND YOUR TEETH?	Y	N
DOES FOOD OR FLOSS CATCH BETWEEN YOUR TEETH?	Y	N	DO YOU USE ANY TOBACCO PRODUCTS?	Y	N
IS YOUR MOUTH DRY?	Y	N	HAVE YOU HAD PERIODONTAL (GUM) TREATMENTS?	Y	N

**HAVE YOU EVER BEEN TOLD YOU NEEDED ANTIBIOTICS PRIOR TO DENTAL TREATMENT? IF YES WHY?** \_\_\_\_\_

HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL TREATMENT? IF SO, WHAT? \_\_\_\_\_

DATE OF YOUR LAST DENTAL VISIT? \_\_\_\_\_ WHAT IS THE REASON FOR YOUR VISIT TODAY? \_\_\_\_\_

**MEDICAL INFORMATION**

MEDICAL DR/PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_

WHAT MEDICATIONS DO YOU CURRENTLY TAKE? \_\_\_\_\_

**ALLERGIES:**

PENICILLIN	Y	N	LATEX	Y	N	SULFA	Y	N	CODEINE	Y	N
ANESTHETIC	Y	N	OTHER	_____							

**HAVE YOU EVER BEEN TOLD THAT YOU NEED TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?** Y N

**WOMEN ONLY**

Are you pregnant? Y N Due Date \_\_\_\_\_ Breastfeeding? Y N Birth control pill? Y N

PLEASE COMPLETE BOTH SIDES



CONFIDENTIAL HEALTH HISTORY

TODAYS DATE \_\_\_\_\_

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD OR CURRENTLY HAVE

Table with 5 columns of medical conditions: Heart Valve Replacement, Rheumatic Fever, Heart Disease/Attack, Heart Murmur, High/Low Blood Pressure, Other, Stroke, Sleep Apnea, Joint Replacement, Diabetes, Drug Addiction, Asthma, Sinus Trouble, GERD, Anorexia/Bulimia, Mental Disorders, Blood Disorder/Disease, HIV or AIDS, Cancer or Tumor, Radiation Treatment, Chemotherapy, Tuberculosis, Lung Disease, Epilepsy, Hepatitis B or C, Liver Disease.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his team members will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. If patient is a minor I acknowledge that I am the responsible party for any treatment rendered.

Signature [Redacted] Date \_\_\_\_\_

INSURANCE PURPOSES ONLY

PRIMARY INSURANCE

EMPLOYEE/SPONSOR \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
SS# \_\_\_\_\_ DOB \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_
EMPLOYER \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

SECONDARY INSURANCE

EMPLOYEE/SPONSOR \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
SS# \_\_\_\_\_ DOB \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_
EMPLOYER \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

I understand and agree that I am responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentists or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of any information relating to my dental treatment to my insurance provider. I hereby authorize payment for dental services rendered to Stonebridge Dental Associates/Gerald L. Coates, Jr., DMD.

Signature [Redacted] Date \_\_\_\_\_

PRIVACY POLICY

Contact Officer Linda White Email linda@stonebridgesmiles.com
Telephone (252) 447-3100 Fax (252) 447-0144
Address 92 Stonebridge Trail, Havelock, NC 28532

If you would like a copy of our privacy policy and how we utilize your information we will be happy to supply you a copy of our HIPAA policy. Your information is not shared with anyone without your expressed consent and authorization.

PATIENT HIPAA ACKNOWLEDGEMENT

I, \_\_\_\_\_, acknowledge that I understand Stonebridge Dental Associates privacy policy and received if I requested so.

Signature [Redacted] Date \_\_\_\_\_

If you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for refusal \_\_\_\_\_

If refused, as HIPAA officer I have reviewed the patients concerns.

Signature \_\_\_\_\_ Date \_\_\_\_\_

RELEASE OF INFORMATION

I, \_\_\_\_\_, hereby authorize release of information to the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Information authorized Dental/Medical Information [ ] Financial Information [ ]

PLEASE COMPLETE BOTH SIDES