Isham Dental

5555 NE Montgomery Blvd NE, Suite #17 • Albuquerque, NM 87109 (505)881-0422

Welcome to our Practice

Chart #:__________
FOR OFFICE USE ONLY

Patient Name:__________________ __________________ ______ __________________
Last First MI Preferred Name

Title: ____________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/Etc

Birth Date:_______________ **SS#:**________-________-__________

Email Address:____

Phone:_______________ _______________ _______________ _______________
Home Mobile Work Other

Address:____ __________________________________
Address 1 Address 2

____ ________ ______________
City State Zip Code

Whom may we thank for referring you to our practice?

____

In case of EMERGENCY, who should be notified? Please enter NAME and PHONE NUMBER below:

____
____

INSURANCE INFORMATION

□ Dental □ SR Plan □ Medicaid □ PPO □ HMO

Insurance Company: ______________________ Group Number: ______________________

Subrscriber/Member ID: ______________________________

MEDICAL HISTORY

Indicate which of the following you have had or at present have. By **Checking the box will indicate a "YES" response**, leaving the box blank will indicate a **"NO"** response

□ *Pre-Med – Amox	□ *Pre- Med – Clindo	□ *Pre-Med – Other	□ Allergies
□ Allergy – Aspirin	□ Allergy – Codeine	□ Allergy – Erythro	□ Allergy – Hay Fever
□ Allergy - Latex	□ Allergy – Other	□ Allergy – Penicillin	□ Allergy - Sulfa
□ Anemia	□ Arthritis	□ Artificial Joints	□ Asthma
□ Bisphophonate Meds	□ Blood Disease	□ Blood Thinner Meds	□ Cancer
□ Diabetes	□ Dizziness	□ Epilepsy	□ Excessive Bleeding
□ Fainting	□ Glaucoma	□ Head Injuries	□ Heart Disease
□ Heart Murmur	□ Hepatitis	□ High Blood Pressure	□ HIV
□ Jaundice	□ Kidney Disease	□ Liver Disease	□ Mental Disorders
□ Nervous Disorders	□ Other	□ Pacemaker	□ Pregnancy
□ Radiation Treatment	□ Respiratory Problems	□ Rheumatic Fever	□ Rheumatism
□ Sinus Problems	□ Stomach Problems	□ Stroke	□ Tuberculosis
□ Tumors	□ Ulcers	□ Venereal Disease	□ FEMALE: Pregnant

□ Ever been hospitalized (illness or injury)
□ Taking medication for weight control (i.e. fen-phen)
□ Subject to frequent headaches
□ FEMALE: Taking birth control
□ Presently being treated for any other illness
□ Taking dietary supplements
□ A smoker or smoked previously

If any condition or alerts selected above needs further clarification, please explain below:

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

____

List all medications, supplements, and/or vitamins taken within the last two years:

____

____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to Inform the office of any changes in my health as soon as possible**

DENTAL INFORMATION

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist's name and how long have you been a patient there:

____

Date of most recent dental exam: ______________________

Date of most recent dental x-rays: ______________________

What is your immediate concern?

____

____

Personal History, Check ALL that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb
☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted
☐ Had any teeth removed

If any of the checked boxes need further explanation, please describe:

____

____

____

____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms as a courtesy. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ **I consent for this practice, ISHAM DENTAL, to communicate with (spouse, family, friend, etc.) _________________________ concerning any dental treatment, financial policy and/or scheduling information**

☐ ***By checking this box, I understand the above information and agree with its contents.**

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit The ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant That they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter Govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to Cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, Upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I Understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web Site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

X____ **Date___ / _____ /_____**