MOUNTAIN VIEW | DENTAL & ORTHODONTICS

2081 East First Street * Alamogordo, New Mexico 88310

Patient Information:

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

Title: Mr./ Ms./ Mrs. Gender: Male / Female

Family Status: Married / Single / Child / Other

Birth Date: _____ SS#: _____-_____-_____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____
Home Work Ext Mobile Other

Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

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

Title: Mr./ Ms./ Mrs. Gender: Male / Female

Family Status: Married / Single / Child / Other

Birth Date: _____ SS#: _____-_____-_____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____
Home Work Ext Mobile Other

Address: _____

City: _____ State: _____ Zip: _____

Primary Dental Insurance:

Name of Insured: _____

Insured Social: _____ Insured DOB: _____

Patient relationship to insured: _____

Insurance Plan Name: _____

Insurance Company: _____

Insurance Subscriber ID: _____

Employer of Insured: _____

Secondary Dental Insurance:

Name of Insured: _____

Insured Social: _____ Insured DOB: _____

Patient relationship to insured: _____

Insurance Plan Name: _____

Insurance Company: _____

Insurance Subscriber ID: _____

Employer of Insured: _____

How did you hear about our practice?

Family / Friend Radio Postcard in the Mail Movie Theater Website Facebook

Whom may we thank for referring you to our practice? _____

In an emergency who should be notified? _____ Phone: _____

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Information Sharing consent Form

I _____, give permission to share information concerning:

- My dental diagnosis and recommended treatment
- The cost and financial arrangements for my treatment
- My personal health information
- Other_____

I give my permission to share the above noted information with:

- My spouse (name)_____
- My parents (name)_____
- My adult child or children (name)_____
- Other_____

I,_____ DO NOT give permission to share ANY information regarding my treatment, financial arrangements or personal health information with the exception of what is outlined in the Mountain View Dental HIPPA policy.

Sign:_____Date:_____

Print:_____Date:_____

TIME 11:25 AM Mountain View Dental DATE 1/3/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ( ) Yes ( ) No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No If yes, please explain: _____
Have you ever had a serious head or neck injury? ( ) Yes ( ) No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ( ) Yes ( ) No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ( ) Yes ( ) No _____
Are you on a special diet? ( ) Yes ( ) No
Do you use tobacco? ( ) Yes ( ) No
Do you use controlled substances? ( ) Yes ( ) No

Women: Are you

Pregnant/Trying to get pregnant? ( ) Yes ( ) No Taking oral contraceptives? ( ) Yes ( ) No Nursing? ( ) Yes ( ) No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ( ) Yes ( ) No	Cortisone Medicine ( ) Yes ( ) No	Hemophilia ( ) Yes ( ) No	Radiation Treatments ( ) Yes ( ) No
Alzheimer's Disease ( ) Yes ( ) No	Diabetes ( ) Yes ( ) No	Hepatitis A ( ) Yes ( ) No	Recent Weight Loss ( ) Yes ( ) No
Anaphylaxis ( ) Yes ( ) No	Drug Addiction ( ) Yes ( ) No	Hepatitis B or C ( ) Yes ( ) No	Renal Dialysis ( ) Yes ( ) No
Anemia ( ) Yes ( ) No	Easily Winded ( ) Yes ( ) No	Herpes ( ) Yes ( ) No	Rheumatic Fever ( ) Yes ( ) No
Angina ( ) Yes ( ) No	Emphysema ( ) Yes ( ) No	High Blood Pressure ( ) Yes ( ) No	Rheumatism ( ) Yes ( ) No
Arthritis/Gout ( ) Yes ( ) No	Epilepsy or Seizures ( ) Yes ( ) No	High Cholesterol ( ) Yes ( ) No	Scarlet Fever ( ) Yes ( ) No
Artificial Heart Valve ( ) Yes ( ) No	Excessive Bleeding ( ) Yes ( ) No	Hives or Rash ( ) Yes ( ) No	Shingles ( ) Yes ( ) No
Artificial Joint ( ) Yes ( ) No	Excessive Thirst ( ) Yes ( ) No	Hypoglycemia ( ) Yes ( ) No	Sickle Cell Disease ( ) Yes ( ) No
Asthma ( ) Yes ( ) No	Fainting Spells/Dizziness ( ) Yes ( ) No	Irregular Heartbeat ( ) Yes ( ) No	Sinus Trouble ( ) Yes ( ) No
Blood Disease ( ) Yes ( ) No	Frequent Cough ( ) Yes ( ) No	Kidney Problems ( ) Yes ( ) No	Spina Bifida ( ) Yes ( ) No
Blood Transfusion ( ) Yes ( ) No	Frequent Diarrhea ( ) Yes ( ) No	Leukemia ( ) Yes ( ) No	Stomach/Intestinal Disease ( ) Yes ( ) No
Breathing Problem ( ) Yes ( ) No	Frequent Headaches ( ) Yes ( ) No	Liver Disease ( ) Yes ( ) No	Stroke ( ) Yes ( ) No
Bruise Easily ( ) Yes ( ) No	Genital Herpes ( ) Yes ( ) No	Low Blood Pressure ( ) Yes ( ) No	Swelling of Limbs ( ) Yes ( ) No
Cancer ( ) Yes ( ) No	Glaucoma ( ) Yes ( ) No	Lung Disease ( ) Yes ( ) No	Thyroid Disease ( ) Yes ( ) No
Chemotherapy ( ) Yes ( ) No	Hay Fever ( ) Yes ( ) No	Mitral Valve Prolapse ( ) Yes ( ) No	Tonsillitis ( ) Yes ( ) No
Chest Pains ( ) Yes ( ) No	Heart Attack/Failure ( ) Yes ( ) No	Osteoporosis ( ) Yes ( ) No	Tuberculosis ( ) Yes ( ) No
Cold Sores/Fever Blisters ( ) Yes ( ) No	Heart Murmur ( ) Yes ( ) No	Pain in Jaw Joints ( ) Yes ( ) No	Tumors or Growths ( ) Yes ( ) No
Congenital Heart Disorder ( ) Yes ( ) No	Heart Pacemaker ( ) Yes ( ) No	Parathyroid Disease ( ) Yes ( ) No	Ulcers ( ) Yes ( ) No
Convulsions ( ) Yes ( ) No	Heart Trouble/Disease ( ) Yes ( ) No	Psychiatric Care ( ) Yes ( ) No	Venereal Disease ( ) Yes ( ) No
			Yellow Jaundice ( ) Yes ( ) No

Have you ever had any serious illness not listed above? ( ) Yes ( ) No _____

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 _____ DATE _____