Please list (2) emergency contact names and numbers:

_____

_____

Financial Responsibility

All professional services rendered are charged to the patient; the PATIENT is responsible for ALL fees the day the service is rendered. If you have dental insurance, you are required to pay the estimated amounts in addition to any other co-insurance/deductibles required by your insurance company on the date of service. Upon completion of insurance payment, the unpaid balance is your responsibility to be paid in full; any overpayment will be refunded to you.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have had the opportunity to review a copy of this office's Notice of Privacy Practices and can receive a copy upon request.
I give the following family/friend(s) permission to access my health information.

_____

_____

Please review the following sections and Initial the blanks provided.

_____ I acknowledge any appointment changes require a 24-hour notice. Three (3) uninformed no show appointments will result in my being dismissed from the practice.

_____ I certify that I have read, answered, and understood all of the previous information on this form to the best of my knowledge. I understand that providing false information could possible be dangerous to my health or illegal in most cases.

_____ I consent to the performing of all procedures mutually decided upon between myself and the doctor to be necessary or in my best interest. If at any point I am uncertain of the risks or benefits of a procedure, I will ask.

_____ I consent to the disclosure of my health information to any other health care provider providing treatment.

_____ I give my consent to Dr. John C. Osborn to appeal on my behalf all insurance inquiries regarding dental treatment and recommendations.

_____ I give my consent to release my medical records to Dr. John C. Osborn if needed for my dental treatment completion.

_____

Patient **OR** Parent's signature (if patient is under 18yrs old) Date

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
◯	◯	Are you taking Birth Control Pills?
◯	◯	Are you pregnant? If Yes, # of weeks ☐
◯	◯	Are you nursing?

Please answer the following:

Y	N		
◯	◯	Do you smoke or use tobacco?	Height: ☐
		For Office Use Only BP ☐ Heart Rate: ☐	Weight: ☐

Y	N	Conditions
◯	◯	Abnormal Bleeding
◯	◯	Alcohol Abuse
◯	◯	Anemia
◯	◯	Angina Pectoris
◯	◯	Artificial Heart Valve
◯	◯	Asthma
◯	◯	Blood Transfusion
◯	◯	Breathing Disorder
◯	◯	COPD
◯	◯	Cancer- Chemotherapy
◯	◯	Chemical Dependency
◯	◯	Congenital Heart Defect
◯	◯	Congestive Heart Failure
◯	◯	Depression
◯	◯	Diabetes
◯	◯	Drug Abuse
◯	◯	Emphysema
◯	◯	Epilepsy
◯	◯	Fever Blisters
◯	◯	HIV+ AIDS
◯	◯	Heart Attack
◯	◯	Heart Disease

Y	N	Conditions
◯	◯	Heart Murmur
◯	◯	Heart Surgery
◯	◯	Hemophilia
◯	◯	Hepatitis A, B, C
◯	◯	High Blood Pressure
◯	◯	High Cholesterol
◯	◯	Human Papilloma Virus HPV
◯	◯	Joint Replacement
◯	◯	Kidney Problems
◯	◯	Leukemia
◯	◯	Liver Disease
◯	◯	Low Blood Pressure
◯	◯	Mitral Valve Prolapse
◯	◯	Pace Maker
◯	◯	Pain In Jaw Joints
◯	◯	Pregnancy
◯	◯	Psychiatric Problems
◯	◯	Radiation Therapy
◯	◯	Rheumatic Fever
◯	◯	Seizures
◯	◯	Special Needs
◯	◯	Stroke

Y	N	Conditions
◯	◯	Thyroid Problems
◯	◯	Tuberculosis
◯	◯	Ulcers
◯	◯	Venereal Disease
☐	☐	
☐	☐	

Y	N	Allergies
◯	◯	Aspirin
◯	◯	Codeine
◯	◯	Dental Anesthetics
◯	◯	Erythromycin
◯	◯	Jewelry
◯	◯	Latex
◯	◯	Metals
◯	◯	Penicillin
◯	◯	Tetracycline

Other

_____

_____

_____

Medications:

Y N

○ ○ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)