Ryan J. Donovan, D.M.D., M.S., P.A.

Periodontics & Dental Implants

NEW PATIENT INFORMATION

Name _____ Birth date___/___/___ Social Security # _____-____-_____

Address _____ City _____ State ____ Zip _____

Home Phone (____) _____-_____ Cell Phone (____) _____-_____ E-mail: _____

Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer: _____ Work Phone (____) _____-_____

Business Address _____ City _____ State ____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____-_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone (____) _____-_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Driver's License # _____ Birth date ___/___/___ Social Security # ____-___-_____

Address _____ City _____ State ____ Zip _____

Currently a Patient in our Office? ☐ Yes ☐ No Home Phone (____) _____-_____

Employer _____ Work Phone (____) _____-_____

INSURANCE INFORMATION

Name of Insured_____ Relation to Patient _____

Birth date ___/___/___ Social Security # ____-___-_____ Date Employed _____

Employer _____ Work Phone (____) _____-_____

Employer Address _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Union or Local #_____

Address _____ City _____ State ____ Zip _____

ADDITIONAL INSURANCE INFORMATION

Name of Insured_____ Relation to Patient _____

Birth date ___/___/___ Social Security # ____-___-_____ Date Employed _____

Employer _____ Work Phone (____) _____-_____

Employer Address _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Union or Local #_____

Address _____ City _____ State ____ Zip _____

Name _____ Birth date_____/_____/_____

MEDICAL HISTORY

Physician's Name_____ Phone # (____) ____-_____ Date of Last Visit ___/___/____

Have you had any serious illnesses or operations? ☐ Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐No If yes, approximate dates _____

Have you ever taken any Bisphosphonates (Boniva, Fosamax, Actonel)? ☐ Yes ☐No

(Women) Are you pregnant? □ Yes □No Due Date:_____ Nursing? □ Yes □ No Taking birth control Pills? □ Yes □No

Check if you have had any of the following:

☐ Allergies, hay fever sinusitis	☐ Chemical Dependency	☐ HepatitisType ____	☐ Sinus Trouble
☐Anemia	☐ Chemotherapy	☐ Herpes	☐ Sickle Cell Anemia
☐Arthritis, rheumatism	☐ Circulatory Problems	☐ High Blood Pressure	☐ Skin Rash
☐Artificial Heart Valves	☐Congenital Heart Lesions	☐Any Immune Deficiency	☐Slow Healing Wounds
☐Artificial Joints	☐Cortisone Treatments	☐Jaundice	☐Osteoporosis
☐ Asthma	☐Cough, persistent or bloody	☐Kidney Disease	☐ Stroke
☐Diabetes Type_____	☐ Liver Disease	☐ Swelling of Feet or Ankles	☐ Emphysema
☐Low Blood Pressure	☐Thyroid Problems	☐Epilepsy	☐ Mitral Valve Prolapse
☐ Tonsillitis	☐ Back problems	☐ Fainting	☐ Pacemaker
☐Tuberculosis	☐ Glaucoma	☐Radiation Treatment	☐Head or Neck Tumor
☐Scarlet Fever	☐Respiratory Disease	☐Ulcer	☐Heart Murmur
☐Rheumatic Fever	☐Venereal Disease	☐Cancer	☐Heart Problems
☐Bleeding Abnormally with Extractions or Surgery	☐Weight Loss (Unexplained)	☐Hemophilia	☐Shortness of Breath
	☐Blood Disease/Clotting Disorders	☐Smoker/Tobacco Use	

List all medications you are currently taking: _____

List any allergies to medications: _____

DENTAL HISTORY

Reason for today's visit _____ Date of Last Dental Visit ___/___/___

General Dentist _____ Date of Last X-Rays ___/___/___

Check if you have had any of the following:

☐ Bad Breath	☐Fingernail Biting	☐Mouth Breathing
☐Food Collection Between Teeth	☐Mouth Pain with Brushing	☐Bleeding Gums
☐Sensitivity to Cold, Hot, Sweets, or Biting	☐Orthodontic Treatment	☐ Blisters on Lips or Mouth
☐ Teeth Grinding / Clenching	☐ Nitrous Oxide (Laughing Gas)	☐ Burning Sensation on Tongue
☐ Growths or Sore Spots in your Mouth	☐ Novacaine or other Local Anesthetic	☐ Chew on One Side of Mouth
☐ Gums Swollen or Tender	☐ Jaw Pain, Clicking, or Popping	☐ Dry Mouth
☐ Periodontal Treatment	☐ Clicking or Popping Jaw	☐ Lip or Cheek Biting

How often do you floss? _____ How often do you brush? _____

Have you ever had an allergic reaction or allergic symptoms to Novocaine, local, or General Anesthesia? ☐ Yes ☐No

AUTHORIZATION & RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize the use of this signature on all insurance forms. I authorize the doctor and his representatives to release all information necessary to assist in securing the payment of my dental benefits. I understand I am financially responsible for all charges whether or not paid by my insurance. In the event my account is balanced with a collection agency, a collection fee of 30% of the then outstanding balance will be added to the account and become a part of the total amount due.

_____ ____/____/____ *Signature of Patient Date*

_____ ____/____/____ *Signature of Doctor Date*

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MESSAGES

The best place to reach me is: ☐ Home ☐ Work ☐ Cell #

If unable to reach me: ☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

RELEASE OF INFORMATION

This ***Release of Information*** will remain in effect until terminated by me in writing.

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child: _____
- ☐ Other: _____

☐ Information **is NOT to be released** to anyone.

NOTICE OF PRIVACY PRACTICES – HIPAA

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ *Date* _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other(Specify)_____