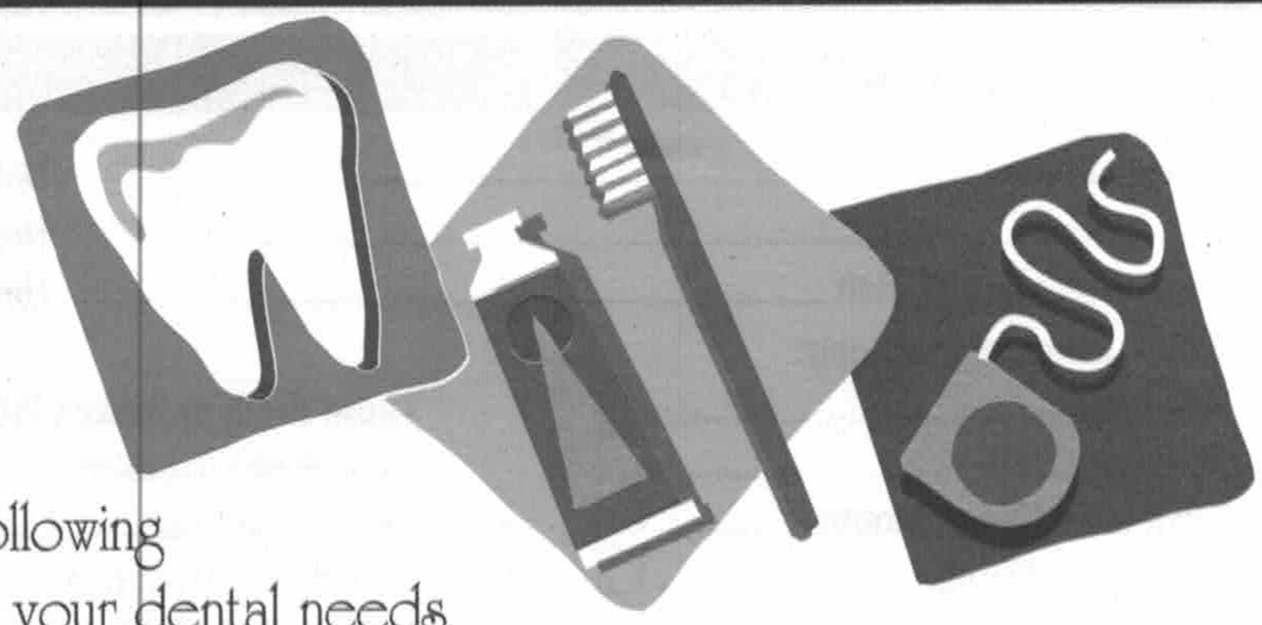
WELCOME
TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____
City, State _____
Date of Last Dental Visit _____
Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐
Bleeding Gums ☐
Blisters on Lips or Mouth ☐
Finger Nail Biting ☐
Grinding Teeth ☐
Lip or Cheek Biting ☐
Loose Teeth or Broken Fillings ☐
Orthodontic Treatment ☐
Pain Around Ear ☐
Periodontal Treatment ☐
Sensitivity to Cold ☐
Sensitivity to Heat ☐
Sensitivity to Sweets ☐
Sensitivity When Biting ☐
Frequent Headaches ☐
Jaw, Head or Neck Injuries ☐
Jaw Difficulty: Clicking and/or Pain ☐
Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

Please describe: _____

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐
Anemia ☐
Arthritis, Rheumatism ☐
Artificial Heart Valves ☐
Artificial Joints ☐
Asthma ☐
Back Problems ☐
Bleeding abnormally, with extractions or surgery ☐
Blood Disease ☐
Cancer ☐
Chemical Dependency ☐
Chemotherapy ☐
Chronic Fatigue Syndrome ☐
Circulatory Problems ☐
Congenital Heart Lesions ☐
Cortisone Treatments ☐
Cough - persistent or bloody ☐
Diabetes ☐
Emphysema ☐
Epilepsy ☐
Fainting or Dizziness ☐
Glaucoma ☐
Headaches ☐
Heart Murmur ☐
Heart Problems ☐
Hepatitis-Type _____ ☐
Herpes ☐
High Blood Pressure ☐
HIV Positive ☐
Jaundice ☐
Jaw Pain ☐
Latex Sensitivity ☐
Kidney Disease ☐
Liver Disease ☐
Low Blood Pressure ☐
Mitral Valve Prolapse ☐
Nervous Problems ☐
Pacemaker ☐
Psychiatric Care ☐
Radiation Treatment ☐
Respiratory Disease ☐
Rheumatic Fever ☐
Scarlet Fever ☐
Shortness of Breath ☐
Sinus Trouble ☐
Skin Rash ☐
Stroke ☐
Swelling of Feet/Ankles ☐
Swollen Neck Glands ☐
Thyroid Problems ☐
Tonsillitis ☐
Tuberculosis ☐
Tumor or growth on head/neck ☐
Ulcer ☐
Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Dr. R. Todd Scanlon, DMD

8657 Watson Rd, Ste E
Webster Groves, MO 63119
(314) 962-2747

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____