BELLA VISTA DENTAL

Welcome to our Bella Vista Dental Family!

We strive to make every visit to our office the best one you can have. Please fill out our new patient paperwork to the best of your knowledge so that we can use it to serve you.

First Name: _____ Middle Initial: _____ Last Name: _____
DOB: _____ Social Security #: _____ Driver's License # _____ State: ____

Gender: M F Age: _____ Best Phone #: _____ Cell Home Work
Address: _____
E-Mail Address: _____
How would you like to be reminded about you appointments? Phone Text Email Mail

Please let us know how you found our office? Please Circle Below

Friend Ad in Mail Drove By Insurance Company Internet Other: _____

Emergency Contact
Name: _____ Contact Phone #: _____
Relationship to you: _____

Insurance Information
Policy Holder Name: _____ DOB: _____
Insured SS #:_____ Relationship to Patient: _____
Member ID#: _____ Group ID#: _____
Insurance Company _____
Address: _____
Insurance Phone #: _____ Employer: _____
Reason for Visit Today: Circle all that Apply

New to the Area	Pain/Swelling	Cosmetic	Cleaning
2nd Opinion	Consult	Whitening	Orthodontics
Wisdom Teeth	Implants	Sleep Apnea	Popping/Clicking Jaw
Tooth Replacement	Dry Mouth	Smoking/Dipping	Snoring

Other: _____
Have you ever needed antibiotic before dental treatment? YES NO
If Yes, Explain _____
Have you been diagnosed with Sleep Apnea? YES NO Do you have a C-Pap? YES NO Is it used regularly? YES NO
Last Dental Visit: _____

Please List ALL MEDICATIONS/VITAMINS you are currently taking: _____

_____

_____

317 S. Hwy 46 Seguin, TX 78155
(830) 379-8902

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Please Circle if you have any of the following:

Acid Reflux	Fainting/Dizziness	Pace Maker	Venereal Disease
Aids/HIV	Glaucoma	Radiation Treatment	Weight Loss
Arthritis	Headaches	Respiratory Disease	Women: Pregnant / Nursing
Artificial Heart Valve	Heart Murmur	Rheumatic Fever	
Artificial Joints	Heart Problems	Shortness of Breath	Seizures/Epilepsy
Asthma	Hepatitis A B C (circle)	Sinus Trouble	Osteoporosis
Blood Disease	High Blood Pressure	Special Diet	Sleep Apnea
Bleeding Abnormally	Jaundice	Stomach/Intestinal Issues	
Bruise Easily	Jaw Pain	Tobacco Use (any form)	
Cancer	Kidney Disease	Thyroid Disease	
Chemotherapy	Latex Allergy	Tuberculosis	
Cough (Persistent/Bloody)	Liver Disease	Tumors/Growths	
Diabetes	Mitral Valve Prolapse	Ulcers	

Are you under any medical treatment now? YES NO
If Yes, Please explain: _____
_____

Have you ever had any adverse/allergy to any drugs/vitamins? YES NO
Please Circle any allergies that apply:

Aspirin	Iodine	Sulfa Drugs	Dental Anesthetics
Barbiturates	Latex Rubber	Penicillin/Amoxicillin	Metals
Codeine			Other: _____

Have you had any wounds healed slowly? YES NO _____
Have you had any excessive bleeding? YES NO _____
Do you chew on one side of your mouth? YES NO If Yes, why? _____
Have you had any major operations? YES NO (if yes, when?)_____
Do you smoke or chew tobacco? YES NO _____
Have you been treated in a hospital in the last 5 years? YES NO _____
_____
_____

Are you currently taking/have you taken any of the following?

Fosamax	Didronel	Actonel	Zometa
Ostac	Boniva	Skelid	Blood Thinners
Bonefos	Aredia		

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DENTAL

_____ I acknowledge that all the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my dental provider with any changes in medical status.

_____ I have been informed of and given the right to review and secure a copy of your Practice Financial Policy.

_____ I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Bella Vista Dental to use and/or disclose my protected health information to carry out the following

- Treatment which includes direct/indirect treatment by the other healthcare providers involved in my treatment
- Obtaining payment from third party payers, (my dental or medical INS company)
- The day to day healthcare operations of your dental practice.

I authorize you to share all my protected health information with the following individuals:

Name	Relationship	Contact Info

_____ I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPPA. I understand I have the right to request restrictions on how my information is used and/or disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction, I understand I any revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent will not be affected.

*For more information about HIPPA and/or to file a complaint:

(202)619-0257 Toll Free: 1(877)696-6775
The US Department of Health & Human Services
200 Independence Ave, S.W.
Washington DC 20201

_____

Patient Name Signature of Responsible Party Date