

Anthony T. Nation, DDS 715.359.0550

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

was offered a copy of this office's notice of Privacy Practices and a copy will be provided in the L tuture upon my request.

{Please Print Name}

(Signature) (Signature of parent or guardian if minor) July 28, 2023

This portion of the form is used to identify the family members, close friends, or other persons to whom we may disclose protected health information about you or notify regarding your care. This form is effective for the duration of your care or until you provide further written notice.

Name:	Relationship to patient:	
Telephone:		
Name:	Relationship to patient:	
Telephone:		
Name:	Relationship to patient:	
Telephone:		

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

For Office Use Only

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

Patient Information Update

Please take a few minutes to review the following information, make any necessary changes, and answer the questions completely. If you provide us with an e-mail address that you check frequently, we'll send appointment reminders to you electronically.

further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit daims for benefits, for services rendere or to be rendered without dotalining my signature on achnowledge that personally signed the particular claim. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Relationship:	Work phone: Cell phone/pager: e-mail: Occupation:	If you are new to our office, who may we thank fo	r referring you					
Description: Cell phone/pager: e-mail: Place of Employment: Any change in your marital status? (If so, what?) Place of Employment: Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Insured Party: Employer/plan: Insurance company: Insurance company: The undersigned hereby subhorizes the release of any information relating to all claims for benefits submitted on behalf of myself and for dependents. further expressly agree and advnowledge that my signature on this document authorizes my doctor to submit claims for benefits. for services render or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by the signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse:	Cell phone/pager: e-mail: Occupation: Place of Employment:	NQMC:			DOB:			
Gen protespager. e-mail: Occupation:	e-mail: e-mail: Spouse's Name:	Address:						
Occupation:	Occupation: Place of Employment: Any change in your marital status? (If so,what?) Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Primary coverage Secondary coverage Insurance Company: Secondary coverage The undersigned hereby authorizes the release of any information relating to all claims for benefits, submitted on behalf of myself and /or dependents. Insurance Company: The undersigned hereby authorizes and advice/dependents. The undersigned hereby authorizes the release of any information relating to all claims for benefits, for services renders. Authorized Signature of Covered Person/Employee Date Medical History / Information Cell: Emergency contact, other than spouse: Cell Medical Doctor: City / Phone:			one/pager:				
Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Primary coverage Secondary coverage Insured Party: Employer/plan: Insurance company: Secondary coverage Insured Party: Employer/plan: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for benefits, submitted on behalf of myself and /or dependents, for services renders or to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by the signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Ceil:	Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Primary coverage Secondary coverage Insured Party: Employer/plan: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for banefits, for services renders or to be rendered without obtaining my signature on sech and every claim to be submitted for myself and for dependents. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Cell:		e-mail.					
Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Primary coverage Secondary coverage Insured Party: Employer/plan: Insurance company: Secondary coverage Insured Party: Employer/plan: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for benefits, submitted on behalf of myself and /or dependents, for services renders or to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by the signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Ceil:	Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed. Primary coverage Secondary coverage Insured Party: Employer/plan: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for banefits, for services renders or to be rendered without obtaining my signature on sech and every claim to be submitted for myself and for dependents. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Cell:	Occupation:	Place of	f Employment:	1 - 4 - 4 - 0 (16 + - + 0)			
claims may be delayed. <u>Primary coverage</u> <u>Secondary coverage</u> <u>Secondary coverage</u> <u>Insured Party:</u> <u>Employer/plan:</u> <u>Insurance company:</u> The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressive agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits. for services renders or to be rendened without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by th signature as though the undersigned hed person/Employee Date <u>Authorized Signature of Covered Person/Employee</u> Date <u>IHEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.</u> <u>Authorized Signature of Covered Person/Employee</u> Date <u>Medical History / Information</u> <u>Emergency contact, other than spouse</u> ; <u>City / Phone</u> ; <u>City / Phone</u> ; <u>City / Phone</u> ; <u>City / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / Phone</u> ; <u>Cits / All Other Allergies</u> to Medications or Other; <u>Cits / Phone</u> ; <u>Cits / Phon</u>	claims may be delayed. Primary coverage Secondary coverage Insured Party: Employer/plan: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressly agree and acknowledge that my signature on this document suthorizes my doctor to submit claims for benefits, for services rendere or to be nondered without oblaining my signature on this document suthorizes my doctor to submit document authorizes my doctor to submit document suthorizes my doctor to submit or benefits and or dependents. Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Home Phone: Home	Spouse's Name:	Any ch	Any change in your marital status? (If so,what?)				
Insurance Ormpany: Employer/plan: Insurance Company: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendere ror to be nefted without obtaining my signature on each and very claim to be submitted for myself and /or dependents and that I will be bound by th signature as though the undersigned had person/Employee Date Authorized Signature of Covered Person/Employee Date IHEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date IHEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date IHEREBY Information Emergency contact, other than spouse: Relationship: Home Phone: Keiting the covered Person/Employee Date City / Phone: Keiting to: Keiti	Insurance Orangany: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressive agrees and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services renderes or to be endered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by th signature as though the undersigned had person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse:		formation and upda	ate it if necessary. I	f we don't have accurate inforn	nation, your		
Employer/pian: Insurance company: The undersigned hereby suthorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. for benefied without obtaining my signature on each and every claim to be submitted for myself and/ or dependents and that I will be bound by it signature as though the undersigned had person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Relationship: Home Phone: List all medications you are currently taking, and why you are taking them: List all medications you are currently taking, and why you are taking them: List all medications you are currently taking, and why you are taking them: Are you taking or have you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa? Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? Y / N	Employeer/plan: Insurance company: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. The undersigned hereby authorizes the release of any signature on each and every claim to be submitted for myself and/ or dependents and that I will be bound by the signature as though the undersigned had personally signed the particular claim. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Home Phone: List all medications you are currently taking, and why you are taking them: List all medications you are currently taking, and why you are taking them: List all medications you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa? Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? Y / N			Secondary c	overage			
Insurance company: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for benefits, and that I will be bound by it signature as though the undersigned had personality signed the particular claim. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date IHEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Home Phone: Cell: Home Phone: Codeine Antibiotics (list below) Please List All Other Allergies to Medications or Other: List all medications you are currently taking, and why you are taking them: List all medications you are currently taking, and why you to take an antibiotic before any dental treatment? Y / N	Insurance company: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressive agrees and acknowledge that my signature on this document authorizes my doctor to usumit claims for benefits, for services renders ror to be rendered without obtaining my signature on acknowledge that my signature on the advery claim to be submitted for myself and/or dependents and that I will be bound by th signature as though the undersigned had personally signed the particular claim. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Home Phone: Home Phone: City / Phone: Cit							
The undersigned hereby authorizes the release of any information relating to all claims for benefits, submitted on behalf of myself and /or dependents, further expressive gare and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/ or dependents and that I will be bound by the sufficient expressive gare and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered without obtaining my signature on the devery claim to be submitted for myself and/ or dependents and that I will be bound by the sufficient expressive gare and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered without obtaining my signature on the devery claim to be submitted for myself and/ or dependents and that I will be bound by the sufficient expressive gare and acknowledge the particular claim. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse:	The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. further expressily agrees and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by th signature as though the undersigned hed person/Employee Date Authorized Signature of Covered Person/Employee Date I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. Authorized Signature of Covered Person/Employee Date Medical History / Information Emergency contact, other than spouse: Home Phone: Home Phone: Home Phone: Home Phone: City /							
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Medical History / Information Emergency contact, other than spouse: Relationship: Home Phone: Work Phone: Cell: Medical Doctor: City / Phone: City / Phone: Allergic to: Latex Codeine Antibiotics (list below) Please List All Other Allergies to Medications or Other: List all medications you are currently taking, and why you are taking them: Are you taking or have you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa? Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? Y / N	Medical History / Information Emergency contact, other than spouse:	THERE I AUTHORIZE PATMENT DIRECTL	TO THE DOCTOR C	F THE GROUP INSUR	ANCE BENEFITS OTHERWISE PAY	ABLE TO ME.		
Emergency contact, other than spouse:	Emergency contact, other than spouse:	Authorized Signature of Covered Person/Employe	e Date	Authorized Sign	ature of Covered Person/Employee	Date		
Emergency contact, other than spouse:	Emergency contact, other than spouse:	Medical History / Information						
Medical Doctor: City / Phone: Allergic to: Latex Codeine Antibiotics (list below) Please List All Other Allergies to Medications or Other:	Medical Doctor:	Emergency contact, other than spouse:						
Allergic to:LatexCodeineAntibiotics (list below) Please List <i>All Other Allergies</i> to Medications or Other: List all medications you are currently taking, and why you are taking them: Are you taking or have you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa? Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? Y / N	Allergic to:LatexCodeineAntibiotics (list below) Please List <i>All Other Allergies</i> to Medications or Other: List all medications you are currently taking, and why you are taking them: Are you taking or have you ever taken a biphosphonate derivative such as Fosamax, Didronel, Aredia, Actonel, Skelid, Boniva, Reclast, Prolia, Xgeva or Zometa? Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? Y / N	Home Phone:	_ Work Phone:		Cell:			
Please List All Other Allergies to Medications or Other:	Please List <i>All Other Allergies</i> to Medications or Other:	Medical Doctor:	City /	Phone:				
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Please list any Surgeries or Hospitalizations you have had in the past 5 years:	Please list any Surgeries or Hospitalizations you have had in the past 5 years:	Has your cardiologist, surgeon or other de	octor ever told you	to take an antibiot	c before any dental treatment?	Y/N		
		Please list any Surgeries or Hospitalization	ons you have had i	n the past 5 years:				

(Due date: _____) Are you taking birth control pills? Y / N Are you pregnant or nursing? Y / N

Patient Information Update (p.2)

Patient:

Do you use nicotine? Y/N Type: Smoke/chew/dip/Ecigs/Vape How often?	For how many years:
Please circle, if you experience Headaches / Back pain / Neck pain: How often?	_ Severity?
Is there anything you want to talk to the doctor about today?	

Do you have or have you had any of the following conditions? (Circle Y or N)

- Y N Heart attack/stroke
- Y N Cosmetic Surgery
- Y N Shingles
- Y N Liver Problems
- Y N Abnormal Heart Condition
- Y N Asthma
- Y N Arthritis/ Rheumatism
- Y N Stomach Problems/Ulcers
- Y N Heart Disease
- Y N Leukemia
- Y N Fainting/ Seizures/ Epilepsy
- Y N Alcohol/ Drug Abuse
- Y N Eating Disorder
- Y N Bleeding Problems

- Y N Thyroid problems
- Y N Heart Surg./ Pacemaker
- Y N Xray or Cobalt Treatment
- Y N Hepatitis
- Y N Respiratory Problems
- Y N Allergy or Hives
- Y N Organ Transplant
- Y N Artificial Bones/ Joints
- Y N Psychiatric Problems
- Y N Congenital Heart Defect
- Y N Anemia
- Y N Glaucoma
- Y N Tuberculosis (TB)
- Y N Nervousness

- Y N Cancer or Tumors
- Y N Kidney Problems
- Y N Infectious Endocarditis
- Y N Chemotherapy
- Y N HIV/AIDS/ARC
- Y N Sinus Problems
- Y N Artificial Heart Valves
- Y N Diabetes
- Y N Emphysema
- Y N Difficulty Breathing
- Y N Chest Pains
- Y N High Blood Pressure
- Y N Hypoglycemia
- Y N Sleep Apnea

Please list any other medical conditions not listed:

The above information is true.

The undersigned hereby authorizes the Doctors and Staff of Dental Associates of Cedar Creek to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% annually) will be added to any balance over 90 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

Signature:			Date: July 28, 2023
Please ch	eck one:Adult patient	Parent or Guardian	Spouse
For office use only:	Entered into computer by	(initials):	Date:

Last prophy: BWX: FMX: Pano: