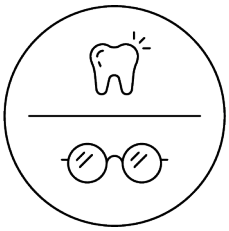

Stanford Family Dental and Vision

Patient Information

Name:_____ Date of Birth:_____ __Male __Female

Social Security Number:_____ Email:_____

Mailing Address:_____ City/State:_____ Zip Code:_____

Home Number:_____ Cell Number:_____

Emergency Contact Name & Phone Number:_____

How will you pay for today's visit? ___Vision Insurance ___Medical Insurance ___Dental Insurance ___ Private Pay

Insurance Information

Subscriber Name:_____ Subscriber Date of Birth:_____

Subscriber's Employer:_____ Subscriber Social:_____

Circle Purpose of Today's Visit: Vision Glasses Contacts Both Other Dental

Are you allergic to: __Penicillin __Latex __Sulfa __Aspirin __Codeine
__ Local Anesthetics __Acrylic __Metal

List any other ALLERGIES that you have:_____

List all MEDICATIONS that you take:_____
_____
_____

Are you pregnant? ___Yes ___ No Are you nursing? ___ Yes ___ No
Do you use? ___ Tobacco ___ Alcohol ___ Controlled Substance

PATIENT Signature(if under 18, a guardian must sign):_____Date:_____

Review of Systems (Self)

For all patients, new and established, we need records of your general health to be able to treat you to the best of our ability. In each area, if you are having no difficulties, please circle 'No Problems'. PLEASE CIRCLE THE ONES THAT APPLY FOR YOUR SELF, or write in any that might not be listed.

Constitution (Health in General): No Problems Developmental Disabilities, Cancer, Fatigue Syndrome, Other:_____

Ears, Nose, Mouth & Throat: No Problems Hearing Loss, Sinusitis, Dry Mouth, Laryngitis, Other:_____

Neurological (Brain & Nerves): No Problems Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraine, Autism, Other:_____

Psychiatric (Mood & Thinking): No Problems Depression, AD(H)D, Anxiety Disorder, Bipolar Disorder, Other:_____

C-V (Heart & Blood Vessels): No Problems Hypertension, Stroke/CVA, Heart Disease, Vascular Disease, Congestive Heart Failure, Other:_____

Resp. (Lungs & Breathing): No Problems Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea, Other:_____

GI (Stomach & Intestines): No Problems Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other:_____

GU (Kidney & Bladder): No Problems Kidney Disease, Prostate disease/cancer, STD-Herpetic/Chlamydia, Benign Prostate Hypertrophy, Pregnant/Nursing, Other:_____

MS (Muscles, Bones, Joints): No Problems Arthritis, Osteoporosis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Gout, Other:_____

Integ. (Skin, Hair & Breast): No Problems Eczema, Rosacea, Psoriasis, Cold Sores, Herpes Zoster (Shingles), Other:_____

Endocrine (Glands): No Problems Type 1 or Type 2 Diabetes, Thyroid Dysfunction, Hormonal Dysfunction, Other:_____

Hematologic (Blood/Lymph): No Problems Anemia, Large-Volume Blood Loss, Ulcer, High Cholestrol, Other:_____

Allergic/Immune: No Problems Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjorgren's, Other:_____

AUTHORIZATION TO RECEIVE TREATMENT AND THE ASSIGNMENT OF BENEFITS

Please read and agree to the following:

1. I authorize this office to perform any necessary treatment that I may need.
2. I authorize this office to bill my insurance for any and all services but understand that I am ultimately financially responsible in the event that my insurance does not pay for services.
3. I agree that all services rendered are due payable at the time of service.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA

I acknowledge that I read a copy of Stanford Family Dental & Vision, LLC Notice of Privacy Practices.

If you would like to amend any of the privacy practices, please state below:_____

Is there anyone other than yourself that has permission to receive or discuss your care or needs? If so, list their name and contact number:

_____

_____

Please check the allowable means of communication: _____e-mail _____text

PATIENT Signature (if under 18, a guardian must sign):

X_____ Date:_____