OLYMPUS VIEW DENTAL

PATIENT INFORMATION

Date

Patient's Name (LAST FIRST MIDDLE) Preferred Name

Social Security # Age Birth Date Male Female

Address Apt. # City State Zip

Driver's License # Issuing State Exp. Date

Marital Status Home Phone Cell Phone

Employer Work Phone Ext. May we contact you there?

In case of an emergency please notify Phone

Whom may we thank for referring you to our office?

Spouse Information (OR Parent Information if Patient is a child under age 18)

Name (LAST FIRST) Social Security # Brithdate

Address Apt. # City State Zip

Employer Occupation Work Phone

Financial Information

Person responsible for payments (LAST FIRST) Relationship to patient

Address Apt. # City State Zip

Employer Occupation Phone

Insurance Information

Dental Insurance Phone Group #

Mailing Address City State Zip

Name of Insured (policyholder) Birthdate Phone

Secondary Dental Insurance (if applicable)

Mailing Address City State Zip

Name of Insured (policyholder) Insurance ID #

HEALTH HISTORY

1. Are you in good health? Yes No

2. Do you have any disease, condition, or problem that you think our office should be aware of? Yes No

(If yes, please explain)

3. Have you been hospitalized or had major surgery recently? Yes No

(If yes, please explain)

4. (Women) Are you pregnant? Yes No

Expected Delivery Date

5. Are you satisfied with the appearance of your smile? Yes No

6. Do you have, or have you ever had any of the following? Check all that apply

- _____ AIDS/HIV Positive
- _____ Anemia
- _____ Artificial Heart Valve
- _____ Artificial Joint Replacement
- _____ Asthma/Hayfever
- _____ Birth Defects
- _____ Blood Clots
- _____ Bruise Easily
- _____ Cancer
- _____ Chest Pain/Angina
- _____ Congenital Heart Disease
- _____ Depression/Pms
- _____ Diabetes
- _____ Difficulty Healing After A Cut
- _____ Dizziness/Fainting
- _____ Eating Disorders
- _____ Emphysema
- _____ Heart Attack/Arrhythmia
- _____ Heart Murmur
- _____ Heart Surgery/Pacemaker
- _____ Hemophilia
- _____ Hepatitis A
- _____ Hepatitis B
- _____ Hepatitis C
- _____ High Blood Pressure
- _____ Hypoglycemia
- _____ Jaundice
- _____ Kidney Disease
- _____ Loss Of Hearing
- _____ Marked Weight Change
- _____ Mitral Valve Prolapse
- _____ Numbness/Tingling
- _____ Persistent Fever
- _____ Persistent Headaches
- _____ Persistent Sore Throat
- _____ Psychiatric Disorder
- _____ Radiation/Chemotherapy
- _____ Rhematic Fever
- _____ Stroke
- _____ Tire Easily/Weakness
- _____ Thyroid Condition
- _____ Tuberculosis
- _____ Tumors/Growths
- _____ Ulcers
- _____ Venereal Disease
- _____ Other _____
- _____
- _____
- _____ NONE

7. Are you allergic or have you had a reaction to any of the following?

- _____ Local Anesthetic (Lidocaine)
- _____ Codeine
- _____ Other Antibiotics
- _____ Penicillin
- _____ Metals
- _____ Latex
- _____ Sulfa Drugs
- _____ Other _____
- _____
- _____ NONE

8. Are you currently taking any of the following medications?

- _____ Allergy/Cold Medicine
- _____ Antibiotics
- _____ Antidepressant
- _____ Asprin/ Arthritis Medicine
- _____ Birth Control Pills
- _____ Blood Pressure Medicine
- _____ Blood Thinners
- _____ Cortisone/ Steroids
- _____ Digitalis/ Heart Medicine
- _____ Dylantin/ Seizure Medicine
- _____ Insulin/ Diabetes Medicine
- _____ Nitroglycerin
- _____ Pain Pills
- _____ Recreational Drugs
- _____ Salt-Free Diet
- _____ Other _____
- _____
- _____
- _____
- _____ NONE

OLYMPUS VIEW
DENTAL

NOTICE OF PRIVACY ACKNOWLEDGMENT

Olympus View Dental
4110 S. Highland Dr. #200
Salt Lake City, UT 84124

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and add will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of the health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name

Relationship to Patient

Signature

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason