



# Welcome to Dr. Christine Theroux Family and Cosmetic Dentistry!

## PATIENT INFORMATION

Date \_\_\_\_\_ Home Phone  
(\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Middle Initial

SS/HIC/Patient ID # \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/ School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## DENTAL INFORMATION

Former Dentist \_\_\_\_\_ Date of last dental care/X-rays \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Other dependents covered \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes  No

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?  Yes  No If so, which drug? \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give dates \_\_\_\_\_

(Women) Are you Pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Rheumatic Fever       |   |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Scarlet Fever         |   |
|  | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Shortness of Breath   |   |

### MEDICATIONS

List any medications you are currently taking

\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 will be used to:

- Conduct, plan and direct my treatment and follow-up among the 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 my 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 above to obtain a current 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 Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_