LEE OVERSTREET, D.D.S.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practice.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refuse to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Patient Information

Date: _____

Patient's Name _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Birthdate: _____ Social Security # _____

If patient is a minor, parent's or guardians name: _____

Whom may we thank for referring you to our office: _____

Responsible Party Information

Name: _____
Last First Middle Marital Status

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____

Previous Address (if less than 3 yrs): _____
Street City State Zip

Social Security #: _____ Birthdate: _____ Relationship to patient: _____

Employer: _____ Occupation: _____ No. yrs employed: _____

Spouse's Name: _____ Relationship to patient: _____
Last First Middle

Employer: _____ Occupation: _____ No. yrs employed: _____

Social Security #: _____ Birthdate: _____ Work Phone: _____

Insurance Information

Insured's Name: _____ Insured's Soc. Sec # _____

Insurance Company _____ Group No.: _____ Local No.: _____

Insurance Co. Address: _____

Do you have dual coverage? Yes ◯ No ◯ If yes:

Insured's Name: _____ Insured's Soc. Sec # _____

Insurance Company _____ Group No.: _____ Local No.: _____

Insurance Co. Address: _____

Insured's Employer: _____

Emergency Information

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____

Medical History

Physician's Name: _____ Last Visit: _____

Address: _____ Phone: _____

Are you being treated by your physician now? ☐Yes ☐No

What is your normal blood pressure?_____/ _____

Are you currently taking any medications? ☐Yes ☐No

If yes, please list _____

Are you allergic to any medication? ☐Yes ☐No

If yes, please list _____

Have you ever reacted adversely to any of the following? ☐No ☐Yes Which?: Local Anesthetic

Aspirin, Darvon, Codeine, Nitrous, Erythromycin, Tetracycline, Valium, Penicillin, Local Anesthetic

Any Recent illness? _____

Please tick any of the following which you have had or presently have:

- ☐ Heart Problems
- ☐ Tested positive for HIV
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Pacemaker
- ☐ Anemia
- ☐ Kidney Troubles
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Diabetes
- ☐ Leukemia
- ☐ Thyroid Disease
- ☐ Heart Murmur
- ☐ Congenital Heart Lesions
- ☐ Treatment with Aredia, Fosamax, Zometa Diet Pills
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Pain in Joints
- ☐ A.I.D.S.
- ☐ Blood Transfusion
- ☐ Ulcers
- ☐ Emphysema
- ☐ Genital Herpes
- ☐ Hay Fever
- ☐ Sickle Cell Anemia
- ☐ Cancer
- ☐ Cold Sores
- ☐ Jaundice
- ☐ Drug Addiction
- ☐ Hemophilia
- ☐ Chemotherapy
- ☐ High Blood Pressure
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Artificial Joints or Heart Valves
- ☐ Metal Plates in Bones
- ☐ Stroke
- ☐ Prolonged Bleeding
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Fainting or Dizziness
- ☐ Psychiatric Treatment
- ☐ Rheumatism
- ☐ Allergies or Hives
- ☐ Nervous Disorders
- ☐ Trauma to Jaw Joints
- ☐ Cosmetic Surgery
- ☐ Radiation Treatment

Do you have any disease, condition, or problem not listed? If yes, please explain: _____

_____

Woman: Are you pregnant now? ☐Yes ☐No

Are you currently using birth control pills? ☐Yes ☐No

Year of Last Dental Visit? _____

Former Dentist Name?_____ City? _____

Consent for Examination and Treatment:

I, the undersigned, have given the above information as correct and true to the best of my knowledge; and hereby authorize Doctor Lee Overstreet to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a through diagnosis of the patient's (Myself or any person whom I have legal responsibility) dental needs. I authorize performance of any and all forms treatment, medication, therapy, that may be indicated in connection with the patient. I 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

Patient: _____ Date: _____

Responsible Party: _____ Relationship to Patient: _____