



Welcome and thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.

PATIENT INFORMATION: (CONFIDENTIAL)

Full Name _____ What would you like us to call you? _____ Sex: M / F
 Street Address _____ City _____ State _____ Zip _____
 Birthdate _____ Social Security # _____ Drivers License #: _____
 Home Phone _____ Work phone _____ Mobile _____
 Employer Name (Patient/Parent's) _____ Employer's Address _____
 Main reason for your visit today? _____
 Email _____ Whom may we thank for referring you? _____
 Previous Dentist _____ Date of last visit _____

To help us make your visit more comfortable, please let us know the following about your previous dental visits:

What you liked most _____ What you liked least _____

Please rate your smile: 1 2 3 4 5 6 7 8 9 10
 (1 = worst, 10 = best)

Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10
 (1 = worst, 10 = best)

PARENT (for minors) /SPOUSE INFORMATION (Please fill out completely.)

MOTHER/WIFE

FATHER/HUSBAND

NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
WORK PH:	CELL:	WORK PH:	CELL:
DL#	DOB:	DL#	DOB:
SS#		SS#	

Person Financially Responsible:

**Please list any of your family members who are patients in our office?

YES NO

PATIENT DENTAL HISTORY

	Do your gums bleed when you brush?
	Do you feel pain in any of your teeth?
	Are you interested in straight teeth in only 6 months?
	Are you interested in whiter teeth in 2 hours?
	Do you grind your teeth at night? Do you have joint / jaw pain?
	Do you snore or gasp for air at night when you sleep? Are you tired all the time?
	Have you ever used a CPAP machine for sleep apnea?
	Are you interested in replacing silver fillings with tooth colored ones?

I authorize Circle C Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Name: _____ Signature of patient _____
 (or parent if patient is a minor)

HEALTH INFORMATION

Medical Physician _____ Office Phone _____ Last Visit _____

Are you under medical care now? (If so, please describe) _____

Please list any medications you are taking (including non prescription) _____

Do you use tobacco products? (Re: cigarettes, smokeless tobacco) _____

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. (Be sure to fill chart out completely.)

* If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.

YES	NO		YES	NO	
		Diabetes			Organ Transplant *
		Rheumatic Fever *			Joint Replacement or Implant *
		Heart Murmur *			Radiation Treatment
		Valve Disorders *			Stroke
		Heart Trouble, Heart Attack			Anemia
		Heart Disease			Frequently Tired or Easily Winded
		Cardiac Pacemaker			Liver Disease
		High or Low Blood Pressure (Please Specify)			Ulcers, Stomach or Mouth
		Asthma			Respiratory Problems, Tuberculosis
		Hepatitis (Specify A, B or C) Year:			Eye or Ear Problems
		Frequent Illness, Lowered Immunity			Epilepsy or Seizures
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + AIDS
		Cancer, Tumors, Cysts			Other:

ALLERGIES

YES	NO		YES	NO		PLEASE LIST ANY OTHER ALLERGIES:	
		Penicillin			Iodine		
		Local Anesthetics			Latex Rubber		
		Aspirin			Sulfa Drugs		
		Codeine					

Is there any other health information we should know?

Are you Pregnant? YES / NO Due Date _____ Nursing? YES / NO Oral Contraceptives? YES / NO
 (Please inform us if you become pregnant.)

Please inform us if your health information should change in any way.

Whom should we contact in case of an emergency? (PLEASE DO NOT LEAVE THIS BLANK)

Name _____ Phone _____ Relationship _____

Closest relative or friend not living with you? _____ Phone _____

To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.

Signature: _____ Date: _____



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NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY:

Our office is required by law to maintain the privacy of your health information, to give you notice about how we do this and what your rights are.

HOW WE USE YOUR HEALTH INFORMATION:

We use your health information for treatment, payment and healthcare operations.

This means- We may discuss your health information with another doctor or healthcare worker involved in your treatment. We may use this information to obtain payment for your treatment from third parties such as insurance companies. We may also use this information for our internal operations such as training and quality assessment and to contact you about appointments using phone, mail or email.

You have the right to decide who else, by specific signed authorization, has access to your health information such as family members, employers, marketing companies or other entities not directly related to our office or your treatment.

We must disclose your health information when required to do so by law or if we believe your health or safety or the health or safety of other is threatened.

YOUR RIGHTS:

You may request, in writing, a copy of your health information. We may charge a reasonable fee for this service. Upon request, a more detailed and lengthy explanation of our policies is available.

Questions and Complaints-If you have any issues concerning the privacy of your health information, you may direct your complaints to the contact person listed below. You may also submit a written complaint to the US Dept. of Health and Human Services.

Contact Officer:

Tuan Pham, DDS
512-301-BITE (2483)
Email: contact@circlecdental.com
9600 Escarpment Blvd Ste 770,
Austin, TX 78749

Thank you for helping our office comply with federal law on health information privacy policies.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's notice of privacy practices.

Please Print Your Name: _____

Signature _____ Date _____

For office use only: We attempted to obtain written acknowledgement of our Notice Of Privacy Practices but could not because- Individual refused to sign, communication barriers existed, an emergency situation (circle one) or other reason _____