



New Patient Information

Dr. Joe L. Carrick

Welcome to our practice!

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We are excited to work with you in building/maintaining a beautiful and healthy smile that will last you a lifetime!

**Patient Information**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ LastName: \_\_\_\_\_

I prefer to be called (Nickname) \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ Apt/Ste # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Driver license # \_\_\_\_\_

Date of Birth (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_ @ \_\_\_\_\_

Primary contact:  Home  Cell  Work  E-mail Best time to call: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

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

**Person to contact in case of an emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Dental History**

Reason for Today's Visit \_\_\_\_\_

Are you currently in pain?  No  Yes: \* Please describe: \_\_\_\_\_

Do you have any dental problem now?  No  Yes \*Please describe: \_\_\_\_\_

Have you ever had trouble with previous dental treatment?  No  Yes \*Please describe: \_\_\_\_\_

Level of anxiety about seeing the dentist: (Least) 1 2 3 4 5 (Most)

Date of: Last dental exam \_\_\_\_\_ Last Cleaning \_\_\_\_\_ Last full mouth x-rays \_\_\_\_\_

Procedure(s) done at last dental visit \_\_\_\_\_

*Dental History continued...*

Previous dentist name \_\_\_\_\_

Why are you changing dentists? \_\_\_\_\_

**How often do you.....**

Have dental examinations? \_\_\_\_\_ Brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

What other dental aids do you use? (Electronic toothbrush, waterpick, ect.) \_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No Do you have frequent headaches?  Yes  No

Do your gums ever bleed?  Yes  No Do you clench or grind your teeth?  Yes  No

Have you noticed any mouth odors or bad tastes?  Yes  No Are your teeth sensitive?  Yes  No

Do you bite your lips?  Yes  No Do you still have your wisdom teeth?  Yes  No

**Have you ever had:**

Periodontal disease/gum treatment  Yes  No Discomfort in your jaw joint  Yes  No

Orthodontic treatment  Yes  No A night guard  Yes  No

Serious injury to the mouth or head  Yes  No Oral surgery  Yes  No

If yes to any of the previous questions, please describe \_\_\_\_\_

Is there anything else about your past dental treatment(s) that you would like us to know? \_\_\_\_\_

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*Medical History*

**Have you been hospitalized or under the care of a medical doctor during the past 2 years?**  Yes  No

If yes, for what? \_\_\_\_\_

Hospital or Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital or Physician's city \_\_\_\_\_ State \_\_\_\_\_

**Have you taken any drugs or medications in the past 2 years?**  Yes  No

**Are you currently taking any medications or drugs?**  Yes  No

If yes, Please list all \_\_\_\_\_

**Have you ever taken Fen-Phen?**  Yes  No

If so, how long ago? \_\_\_\_\_

**Have you been to the doctor to check for heart problems?**  Yes  No

If so, what are the problems? \_\_\_\_\_

**Do you use tobacco?**  Yes  No **Do you use alcohol or any other controlled substances?**  Yes  No

**Women only:** Are you taking birth control pills?  Yes  No Are you nursing?  Yes  No

Are you pregnant or think you might be pregnant?  Yes  No

*Medical History Continued...*

**Indicate which of the following you have had or have present:**

AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Renal Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N
Alzheimer's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N	Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B or C	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Easily Winded	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Angia	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives / Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Sickle Cell Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypoglycemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Joint	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Irregular Heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Spina Bifida	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling of Limbs	<input type="checkbox"/> Y <input type="checkbox"/> N
Breathing Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Genital Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors or Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pains	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Parathyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Pace Maker	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation Treatments	<input type="checkbox"/> Y <input type="checkbox"/> N	Yellow Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N
Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Please List any serious medical condition (s) that you have ever had not listed above:** \_\_\_\_\_

**Are you aware of having an allergic (or adverse) reaction to any of the following:**

- |              |  |                |  |              |  |
|--------------|--|----------------|--|--------------|--|
| Asprin       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jewelry/Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetics  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other        | _____  |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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## *Dental Insurance*

### **Primary Carrier:**

Insurance co. name \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_  
Group # \_\_\_\_\_ Member ID \_\_\_\_\_ Policy # \_\_\_\_\_  
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
DOB \_\_\_\_\_ Social Security # \_\_\_\_\_  
Insured's employer name \_\_\_\_\_ Is Insured a patient in our practice?  Y  N

### **Person Financially Responsible for Account: (If someone other than patient)**

Today's Date: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
I prefer to be called (Nickname) \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ Apt/Ste # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Driver license # \_\_\_\_\_ Phone # \_\_\_\_\_

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## *Financial Policy*

**Payment is due in full at time of treatment**  
*(Unless prior arrangements have been approved)*

I understand that I am responsible for payment of services rendered at the time of dental treatment. As a courtesy, we will be happy to file your dental insurance and assign benefits to you. We will attempt to provide an **estimate** of your reimbursement. The contract for coverage is between you and your insurance company and it is impossible for us to be familiar with all plans. In the event that we have made an arrangement to accept benefits or perhaps to do so in the future, a signature is required. If this arrangement is made, you will be asked to register a valid credit card with us so that we may apply any remaining balance immediately upon receiving the insurance payment. In addition, in order for us to answer any questions regarding your treatment and facilitate your reimbursement, please provide a signature authorizing us to do so.

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

**Preferred Payment Method:**  Cash  Credit Card  Check  Care Credit  Chase Financing  Springstone

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### **OFFICE USE ONLY**

**I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION WITH THE PATIENT**

**DATE** \_\_\_\_\_ **INITIALS** \_\_\_\_\_ **PRINTED NAME** \_\_\_\_\_

□□ **CARRICK DENTISTRY PA** □□  
*HIPAA CONSENT FORM*

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**PATIENT GIVING CONSENT:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**TO THE PATIENT:**

Purpose of Consent: By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options.

Notice of Privacy Practice: This notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

Right to Revoke: You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**The Patient Understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practice. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activity, and care options.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Patient  
(If other than patient): \_\_\_\_\_