



## PATIENT INFORMATION

**Today's Date:**     \_ / \_ / \_

**Patient Name:** \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_

**Birth date:** \_ / \_ / \_\_\_\_ **Age:** \_\_\_\_\_

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

**Email:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work: \_\_\_\_\_

**Gender:** M/F

**Marital Status:**  Married  Widowed  
 Separated  Divorced  Single  Minor

**Social Security #** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

### **IN CASE OF EMERGENCY, CONTACT**

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

**Relation:** \_\_\_\_\_

**Phone:** Home: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work: \_\_\_\_\_

Whom May we thank for referring you?  
**Name:** \_\_\_\_\_

### **DENTAL INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_

Subscriber's Birth date: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_

Subscriber's Birth date: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_

**Assignment and Release:** I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Townsley all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. The above named dentist may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this document, I agree to give Dr. Townsley permission to distribute any relevant treatment or medical information to specialists that may be included in my treatment plan.

**Responsible Party: (Print)** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Dr. Samuel Townsley, DDS  
101 North Cedar Street  
Foley, AL 36535  
251-943-1521



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for Samuel Townsley, DDS, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Please PRINT Name

\_\_\_\_\_  
Please SIGN Name

If you are the legal representative of the patient, please print the name (s) and describe your relationship/authority \_\_\_\_\_

### DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Samuel Townsley, DDS, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions on my behalf. These individuals will be considered my emergency contacts. Without authorization, NO information may be shared. I authorize Samuel Townsley, DDS; to disclose my personal health information with the following people: **PLEASE PRINT**

Name:	Relationship:	Phone #
Name:	Relationship:	Phone #
Name:	Relationship:	Phone #

Samuel Townsley, DDS  
101 North Cedar Street • Foley, AL 36535 • 251-943-1521 • 251-943-1523  
Fax www.TownsleyDental.com

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments       | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss         | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol      | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis          | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_