

*iSmile :)*  
**Richard Ragnell, D.D.S.**  
**1320 Village Creek #100 Plano, TX 75093**  
**972-732-1818 [www.iSmile-tx.com](http://www.iSmile-tx.com)**

Welcome to our practice! Please take a moment to enter OR update your information to help us ensure the quality of your dental is excellent. We are so glad you are here!

**PATIENT'S INFORMATION**

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Home Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Preferred method of appt confirmation    Email    Home Ph    Cell Ph    Text    *(Circle all that apply)*

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status:    Single    Married    Separated    Divorced    Widowed    *(Circle One)*

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

Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Bus Ph \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_ Bus Ph \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

**PERSON TO CONTACT IN AN EMERGENCY**

Relationship \_\_\_\_\_

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_

Who may we thank for referring you \_\_\_\_\_

Reason for this visit \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

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

**SECONDARY INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Subscriber ID \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_ Insurance Co \_\_\_\_\_

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

## HEALTH HISTORY

**For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you.**

### ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

#### \*DENTAL HEALTH HISTORY

Your Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ How Long? \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of last dental cleaning \_\_\_\_\_ Last X-Rays \_\_\_\_\_

Check any of the following you have had or currently have:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Mouth Discomfort                   | <input type="checkbox"/> Grind or Clench your teeth              | <input type="checkbox"/> Close relative that wears dentures                        |
| <input type="checkbox"/> Red, swollen or bleeding gums      | <input type="checkbox"/> Clicking, Popping or Pain in Jaw Joints | <input type="checkbox"/> Gum Abscesses   |
| <input type="checkbox"/> Orthodontic Treatment              | <input type="checkbox"/> Bad Dental Experience                   | <input type="checkbox"/> Complications with or following previous dental treatment |
| <input type="checkbox"/> Sensitive Teeth (hot, cold, sweet) | <input type="checkbox"/> Wake with Sore Jaw                      | <input type="checkbox"/> Fear of Dental Treatment                                  |
| <input type="checkbox"/> Gums Bleed when Brushing           | <input type="checkbox"/> Mouth Odor or Bad Taste                 | <input type="checkbox"/> Stained Teeth   |
| <input type="checkbox"/> Loose or Shifting Teeth            | <input type="checkbox"/> Cold Sores or Fever Blisters            | <input type="checkbox"/> Broken/Chipped Tooth                                      |
| <input type="checkbox"/> Trouble Chewing or Speaking        | <input type="checkbox"/> Other Oral Lesions                      |  |
| <input type="checkbox"/> Bruise Easily                      | <input type="checkbox"/> Lost/Broken Fillings                    |  |
| <input type="checkbox"/> Locking Jaw                        | <input type="checkbox"/> Ringing in Ears                         |  |

#### \*MEDICAL HEALTH HISTORY

How would you describe your present health?    Excellent    Good    Fair    Poor    (Circle One)

List your current physicians:

\_\_\_\_\_ Type \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Type \_\_\_\_\_ Phone \_\_\_\_\_

Date of last complete physical exam \_\_\_\_\_ Purpose \_\_\_\_\_

Findings \_\_\_\_\_

#### Circle Yes or NO

#### Explain

- |   |     |    |                                 |
|---|-----|----|---------------------------------|
| Are you aware of any changes in your general health in the last year?     | YES | NO | _____                           |
| Have you ever been hospitalized for illness or surgery in the past 2 yrs? | YES | NO | _____                           |
| Have you been under a medical doctor's care in the past 2 yrs?            | YES | NO | _____                           |
| Have you had excessive bleeding that required special treatment?          | YES | NO | _____                           |
| Is there any history of diabetes in your family?                          | YES | NO | _____                           |
| Are you required to restrict your work activity in any way?               | YES | NO | _____                           |
| Are you on a specific restricted diet of any kind?                        | YES | NO | _____                           |
| Do you Smoke?   | YES | NO | How much? _____ How Long? _____ |
| Do you snore?   | YES | NO |                                 |
| Do you consume alcohol?   | YES | NO |                                 |
| When you wake up in the morning do you feel rested?                       | YES | NO | _____                           |
| Do you fatigue easily as the day progresses?                              | YES | NO | _____                           |

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Vibramycin	Novacaine	Tylenol	Codeine	Other_____
Erythromycin	Sulfa Drugs	Carbocaine	Aspirin	Ibuprofen	_____
Tetracyclin	Keflex	Xylocaine	Latex	Anesthetics	_____

**\*Indicate which of the following you have had or have at present. Circle YES or NO**

Heart Trouble	YES	NO	Artificial Joint (knee, Hip)	YES	NO	Cancer or Tumors	YES	NO
Heart Disease or Attack	YES	NO	Kidney, Bladder Trouble	YES	NO	Radiation Treatment	YES	NO
Angina	YES	NO	Thyroid Disease	YES	NO	Chemotherapy	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Arthritis/Rheumatism	YES	NO
Low Blood Pressure	YES	NO	Persistent Cough	YES	NO	Glaucoma	YES	NO
Heart Murmur	YES	NO	Tuberculosis	YES	NO	Contact Lenses	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Hepatitis	YES	NO
Congenital Heart Lesions	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Artificial Heart Valve	YES	NO	Sinus Troubles	YES	NO	Jaundice	YES	NO
Scarlet Fever	YES	NO	Allergies or Hives	YES	NO	A.I.D.S./H.I.V.	YES	NO
Heart Pacemaker	YES	NO	Diabetes	YES	NO	Blood Transfusion	YES	NO
Heart Surgery	YES	NO	Frequent Thirst and/or			Drug or Alcohol Addiction	YES	NO
Shortness of Breath			Urination	YES	NO	Hemophilia	YES	NO
Upon Mild Exertion	YES	NO	Stroke	YES	NO	A Nervous Person	YES	NO
Require more than			Epilepsy or Seizures	YES	NO	Ulcers	YES	NO
Two pillows to sleep	YES	NO	Frequent Headaches	YES	NO	Bisphosphonates Therapy	YES	NO
Ankles Swell	YES	NO	Fainting or Dizzy Spells	YES	NO	Psychiatric Care	YES	NO
Anemia	YES	NO	Latex Allergy	YES	NO	Unintentional Weight		
Sickle Cell Disease	YES	NO	Osteoporosis	YES	NO	Gain/Loss	YES	NO
Osteopenia	YES	NO	Sleep Apnea	YES	NO	Recreational Drug Use	YES	NO

**\*If Female are you:**

Pregnant	YES	NO	Through with Menopause	YES	NO
Taking Birth Control	YES	NO	Taking Hormone Medication	YES	NO

**\*Do you have any medical condition/disease not listed on this page that we should know about?**

YES    NO    Explain \_\_\_\_\_

**Please list all medications you are now taking, including any over the counter medications and supplements:**

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

**Pharmacy Name and Telephone Number** \_\_\_\_\_

*To the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform the doctor on or before my next appointment without fail.*

\_\_\_\_\_  
 Patients Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_\_  
 Date





**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement but, in refusing we  
will not be allowed to process your insurance claims.

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

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for  
\_\_\_\_\_. A copy of this signed, dated document shall be as effective  
as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST  
TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

\_\_\_\_\_  
Please **print** your name

\_\_\_\_\_  
Please **sign** your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:  
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

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

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

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

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS,  
TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Phone Confirmation
- Text Message to my Cell Phone
- Email Confirmation
- U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- Message on Cell Phone
- Message on Home Phone
- Message on Work Phone
- Text Message
- Email Message
- U. S. Mail / Postcard
- Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- Phone Message
- Text Message
- Email
- U. S. Mail / Postcard
- Any of the above**

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment \_\_\_\_\_
- I could not communicate with the patient \_\_\_\_\_
- The patient refused to sign \_\_\_\_\_
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature of Privacy Officer