MICHELLE METCALF
CONTEMPORARY DENTISTRY

Patient Information

Date_______________

Name:____I Prefer to be called: ________________________
Address:____City:_____________State:_________Zip:______________
Phone (______)_________________Work Phone (_____)______________Cell Phone (______)___________________
The best time to contact me is:________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____________Social Security Number:_________________Occupation:______________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School:___________________________City/State:__________________________ ☐ FT ☐ PT
Spouse's Name:___________________________Physicians Name:________________Phone__________________
Whom may we thank for referring you? ____
Person to contact in case of emergency:_________________________________Phone:______________________
Email Address:______________________________________
Would you like to receive text message appointment confirmations from our office? ☐ Yes ☐ No

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____Social Security #: _______________________
Address:____
City:_____________________________State:__________Zip:____________Phone: (_____)____________________
Employer:______________________Work Phone: (_____)_________________Address:__________________________

Insurance Information

Name of Insured:______________________________DOB:______________Relationship to Patient: ______________
SSN#:______________________Name of Employer:______________________Work Phone: (_____)______________
Address of Employer:________________________________City:_________________State:________Zip:__________
Insurance Company:___________________________Grp #_____________________ID#_____________________
Ins Co Address:____Ins Co. Phone:___________________________

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured:______________________________DOB:______________Relationship to Patient:______________
SSN#:______________________Name of Employer:______________________Work Phone: (_____)______________
Address of Employer:________________________________City:_________________State:________Zip:__________
Insurance Company:___________________________Grp #_____________________ID#_____________________
Ins Co Address:____Ins Co. Phone:___________________________

Signature:____Date:_______________________________

PATIENT NAME ______________________________ DATE ______________

MEDICAL HISTORY

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 If yes, please explain:______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes, please explain:______________________

Are you on a special diet? ◯Yes ◯No If yes, please explain:______________________

Do you use tobacco? ◯Yes ◯No If yes, please explain:______________________

Do you use controlled substances? ◯Yes ◯No If yes, please explain:______________________

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 ◯Acrylic ◯ Metal ◯ Latex ◯Local Anesthetics ◯Sulfa Drugs ◯Other If Yes, please explain_______________________________

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes-Last A1C____	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Family history of diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Drug Addiction/Alcoholism	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problem	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Stomach/Intestinal Disease	Yes	No
Bruise Easily	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Glaucoma	Yes	No	Marijuana Use	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Yellow Jaundice	Yes	No
			Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No			
			Family history of heart disease	Yes	No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:______________________________

MICHELLE METCALF
CONTEMPORARY DENTISTRY

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Michelle Metcalf, DMD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Michelle Metcalf, DMD reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family ◯ YES ◯ NO

Spouse only ◯ YES ◯ NO

Other (Please Specify): ◯ YES ◯ NO

PRINT Name of Patient or Personal Representative

SIGN Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Office Use Only Below This Line

Provided prior to treatment? YES NO

Date provided:

Reason for denial: Needed more time to review statement of privacy practices.

Wanted to consult with another person, before signing.

Unable to sign. Reason not given.

Other (Explain):

Effective date: 2-16-26