

Name: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

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

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Employer Information**

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care or Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we contact in the case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_ Phone: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

**Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer/ID# \_\_\_\_\_

Insurance company address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have Secondary Insurance? \_\_\_ Yes \_\_\_ No

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer/ID# \_\_\_\_\_

Insurance company address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medical History:** Do you have or had any of the following (Please circle)

- |                          |                      |                            |                         |
|--------------------------|----------------------|----------------------------|-------------------------|
| AIDS                     | Anemia               | Arthritis/Rheumatism       | Artificial Heart Valves |
| Artificial Joints        | Back Problems        | Bleeding Abnormalities     | Blood Disease           |
| Cancer                   | Chemical Dependency  | Chemotherapy               | Circulatory problem     |
| Congenital Heart Lesions | Cortisone Treatments | Diabetes                   | Epilepsy                |
| Fainting                 | Glaucoma             | Headaches                  | Heart Murmur            |
| Heart Attack             | Heart Problems       | Hemophilia                 | Hepatitis               |
| High Blood Pressure      | HIV Positive         | Kidney Disease             | Liver Disease           |
| Mitral Valve Prolapse    | Pacemaker            | Psychiatric Care/ Problems | Radiation Treatment     |
| Respiratory Disease      | Rheumatic Fever      | Shortness of Breath        | Skin Rash               |
| Sinus Problems           | Stroke               | Thyroid Problems           | Tobacco Habit           |
| Tuberculosis             |                      |                            |                         |

Are there any other health conditions you have that are not listed? If so, please explain:

\_\_\_\_\_

Please List all Allergies:

\_\_\_\_\_

Please List all Medications You are Taking:

\_\_\_\_\_

**Women Only:**

Are you Pregnant?  Yes  No Nursing?  Yes  No Had an exposure to HPV?  Yes  No

Date of Last Dental Exam: \_\_\_\_\_ Reason for Today's Visit: \_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I

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will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment at Carl G. Lebo, D.D.S., P. C. is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- ❖ During treatment, we may find it necessary to acquire a laboratory analysis.
- ❖ For payment purposes, we may use the services of a billing service.
- ❖ During healthcare operations, we may need a second opinion.

*(Include any other examples of situations where Protected Health Information may be shared.)*

We at Carl G. Lebo, D.D.S., P. C. are committed to obeying all Federal, State and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

**Carl G. Lebo, D.D.S., P. C.**

**Ph. 703-525-0233**

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I have read and understand the above Notice of Privacy Practices.

Signed \_\_\_\_\_ Date \_\_\_\_\_