

Patient Information

Patient name: _____ Date of birth: ____/____/____

Last

First

Middle Initial

Age: _____ Sex: Male / Female What name do you wish to be addressed? _____

Marital status: Married / Single / Child / Widowed

Home address: _____

City: _____ State: _____ Zip: _____ Home #: _____

Cell #: _____ E-mail: _____ SS #: _____ - _____ - _____

Driver's license #: _____

Emergency contact: _____ **Phone #:** _____

Last

First

Referred to us by / how did you hear about us: _____

Are you currently under a physician's care? NO / YES Reason: _____

Name of your medical doctor: _____ Date of last visit: ____/____/____

Name of previous dentist: _____ Date of last visit: ____/____/____

Are you pregnant? NO / YES

Expected delivery date: _____

Are you nursing? NO / YES

Are you taking birth controls? NO / YES

Dental Health History

Reason for seeking dental care at this time: _____

Are you apprehensive about dental treatment: No Somewhat Yes

Do you have any of the following? Mark all that applies.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Aching or sensitive teeth | <input type="checkbox"/> Broken tooth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Lumps in mouth |
| <input type="checkbox"/> Areas of food traps | <input type="checkbox"/> Chewing on one side | <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking or popping in jaw | <input type="checkbox"/> Gum infection | <input type="checkbox"/> Sensitivity |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Swelling in mouth |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Difficulty opening wide | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Broken filling | <input type="checkbox"/> Other: _____ | | |

Do you snore or have been told that you snore? NO / YES

If you could change your smile, what would you change? Mark all that applies.

- | | | |
|---|--|---|
| <input type="checkbox"/> Remove silver fillings | <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Straighten teeth |
| <input type="checkbox"/> Close gaps between teeth | <input type="checkbox"/> Change shape of teeth | <input type="checkbox"/> Whitening |
| <input type="checkbox"/> Other: _____ | | |

Patient / Guardian Signature: _____ **Date:** ____/____/____

Medical History

Do you have any of the following? Mark all that applies:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Cold sores / Herpes | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Congenital heart disorder | <input type="checkbox"/> High / Low blood pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives / Rash | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Inner ear disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Fainting or dizzy spells | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Surgical prosthesis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Taking heart medications |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers / Stomach problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric care | |

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

List all medications and dietary supplements you are taking including the dosage: _____

Are you required to pre-medicate before a dental appointment? NO / YES

Allergies

Mark all medications or health care related substances to which you have experienced an adverse reaction.

- | | | | | | |
|-------------------------------------|---------------------------------------|--------------------------------|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Latex | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local anesthetics |
| <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ | | | | |

Privacy Policy

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. A copy of our Privacy Policy is available upon request.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, (please print name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient / Guardian Signature: _____ **Date:** ____/____/____

Dental Insurance Information and Insurance Agreement

Primary Dental insurance: _____ Phone #: _____
Subscriber's name: _____ Date of birth: ____/____/____
Subscriber's SS #: _____ - _____ - _____
ID#: _____ Group #: _____

Secondary Dental insurance: _____ Phone #: _____
Subscriber's name: _____ Date of birth: ____/____/____
Subscriber's SS #: _____ - _____ - _____
ID #: _____ Group #: _____

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

Patient / Guardian Signature: _____ **Date:** ____/____/____

Consent for Treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs.

I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

I understand that the proposed treatment may change for unforeseen reasons and that I am responsible for the work done.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. I understand that payment by my insurance is not guaranteed and fees collected at the beginning of services are estimated.

I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Patient / Guardian Signature: _____ **Date:** ____/____/____