Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ______
Soc. Sec. # ______
Date ______

Patient Information (CONFIDENTIAL)

Name ______ Birthdate ______ Home Phone ______
Address ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School / College ______ City ______ State/ Prov. ______ ☐ Full Time ☐ Part Time
Patient's or Parent's Employer ______ Work Phone ______
Business Address ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
Spouse or Parent's Name ______ Employer ______ Work Phone ______
Whom May We Thank for Referring You? ______
Person to Contact in Case of Emergency ______ Phone ______

Responsible Party

Name of Person Responsible for this Account ______ Relationship to Patient ______
Address ______ Home Phone ______
Driver's License # ______ Birthdate ______ Financial Institution ______
Employer ______ Work Phone ______ SSN# ______
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______ Relationship to Patient ______
Birthdate ______ Social Security # ______ Date Employed ______
Name of Employer ______ Union or Local # ______ Work Phone ______
Address of Employer ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
Insurance Company ______ Group # ______ Policy/ID # ______
Ins. Co. Address ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
How Much is your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______ Relationship to Patient ______
Birthdate ______ Social Security # ______ Date Employed ______
Name of Employer ______ Union or Local # ______ Work Phone ______
Address of Employer ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
Insurance Company ______ Group # ______ Policy/ID # ______
Ins. Co. Address ______ City ______ State/ Prov. ______ ZIP/Post. Code ______
How Much is your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit ______

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Exam ____________

	Yes	No
1. Are you under medical treatemnt now ?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within 5 yrs? If yes please explain ______________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If Yes, what are you taking? ______________________	☐	☐
4. Have you ever taken Phen-Fen/redux, fosamax, bonuva and biophosphonate?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have or have you had any of the following?		

9. Are you allergic or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐

10. Women Only *ANTIBIOTIC INHIBITS THE EFFECTIVENESS OF CONTRACEPTIVE

	Yes	No
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
Hig Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Glaucoma	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Sexually Transmitted Disease	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	AIDS or HIV Infection	☐	☐
Epilepsy / Convulsion	☐	☐	Hepatitis / Jaundice	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Stomach Troubles / Ulcers	☐	☐
Kidney Diseases	☐	☐	Cancer	☐	☐	Respiratory Problems	☐	☐
Tuberculosis	☐	☐	Chemotherapy	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Radiation Therapy	☐	☐	Other ______________	☐	☐

Patient Dental History

Oncologist ______________________ Phone No. ______________

Name Of Previous Dentist and Location ______________________________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sore or lumps in or near your mouth?	☐	☐
6. Have you had any head or neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parents if minor)

Doctor's comment ____

GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: ____

DENTISTRY AND THE INDIVIDUAL DENTIST: I undestand that Dentistry is not an exact science and that a reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. **Initial** ___________

DRUGS AND MEDICATIONS: I understand antibiotics and analgesics and other medication can lead to allergic reactions causing redness, swelling of tissue, pain, itching, vomiting and anaphylactic shock (severe allergic reaction). I understand when using local anesthethics bruising can develop. **Initial**___________

CHANGES IN TREATMENT PLAN: I understand that during treatment it maybe necessary to change or add procedures because of conditions found while working on the tooth that were not discovered during examination. The most common being root canal therapy folowing restorative procedures. I understand that changes & additions maybe necessary, but will be explained to me. **Initial** ___________

ORAL SURGERY (TOOTH REMOVAL): I understand removing teeth does not always remove all the infection. If present, it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, drysocket, loss of feeling in my teeth, lips, tounge, sorrounding tissue (paresthesia that can last for an indefinite period of time) and/ or jaw fracture. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, that cost of which is my responsibility. Sinus communication can result from extraction of upper molars. Also extraction of lower molars can result in tooth being pushed into submandibular space. **Initial** ___________

CROWNS, BRIDGES AND CAP: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I maybe wearing temporary crowns, which may come off easily & that I must be careful to ensure that they are kept on until permanent crowns delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size & color) will be before cementation. I understand when a bridge is cemented it is important that I use a bridge threader with floss to properly clean it. I also understand that unless otherwise agreed all crowns for molars are metal crowns (not porcelain). **Initial** ___________

DENTURES (COMPLETE OR PARTIAL): I realize that full or partial dentures are artificial teeth, constructed of plastic, metal or porcelain. Some problems may arise (including shape, fit, size, placement or color) will be the teeth in wax try -in visit. I understand that most dentures require relining approxiately 12 months after initial placement. The cos for this procedure is not included in the initial denture fee. With immediate dentures the time for reline will be 6 months & this charge isn't included in initial fee. **Initial** ___________

ENDODONTIC TREATMENT (ROOT CANAL THERAPY): I realize there is no guarantee that root canal treatment will save my tooth & that complications can occur from the treatment & that occasionally objects are cemented in the tooth that may extend past the root. This does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). Also in some teeth the nerve canals become calcified because of long-standing infection & we can't completely file & clean the canals. This may or may not affect success. **Initial** ___________

PERIODONTAL LOSS (INVOLVING GUMS, TISSUE & BONE): I understand serious periodontal problems can lead to the loss of teeth. I understand it is very important that I follow through with periodontal work including post-operative re-evaluation. I also understand that long standing gum and bone problems are chronic infection and can lead to stroke, heart disease, lung disease, diabetes, gastric ulcer, osteoporosis and pre-term babies. **Initial**___________

TEMPOROMANDIBULAR JOINT (TMJ): Problems can develop from any kind of dental procedures conducted for any length of time. It is my responsibility to alert the Dentist when experiencing jaw soreness or pain. **Initial** ___________

SIGNATURE______________________________ **DATE**__________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ________________________________
(PRINT NAME PLEASE)

Signature: ____ Date: ____________

Witness: ____ Date: ____________

Full Name:______________________________ Date entire form completed:____________

Email address: ____

Patient Screening for Aerosol Transmissible Diseases (ATD)

IN COMPLIANCE WITH CCR, TITLE 8, SECTION 5199, dental facilities must pre-screen patients for ATD. Dental procedures are not performed on a patient suspected or identified as having ATD. We use this form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk.

Do you have:

A history of Tuberculosis (TB)? Y N If yes, explain: ______________________

Symptoms of TB?

Productive cough (>3 weeks): Y N If yes, explain: ______________________

Bloody sputum: Y N If yes, explain: ______________________

Night sweats: Y N Malaise: Y N Fever: Y N

Fatigue: Y N Unexplained Weight Loss: Y N

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

Y N If yes, please list: ______________________

Fever? Y N If yes, how long? _______ Explain: ______________________

Body aches? Y N If yes, how long? _______ Explain: ______________________

Runny nose? Y N If yes, how long? _______ Explain: ______________________

Sore throat? Y N If yes, how long? _______ Explain: ______________________

Headache? Y N If yes, how long? _______ Explain: ______________________

Nausea? Y N If yes, how long? _______ Explain: ______________________

Vomiting and Diarrhea? Y N If yes, how long? _______ Explain: ______________________

Fever and Respiratory Symptoms? Y N If yes, how long? _______ Explain: ______________________

Severe Coughing Spasms? Y N If yes, how long? _______ Explain: ______________________

Painful, swollen glands? Y N If yes, how long? _______ Explain: ______________________

Skin rash, blisters? Y N If yes, how long? _______ Explain: ______________________

Stiff neck, mental changes? Y N If yes, how long? _______ Explain: ______________________

Chronic Respiratory Diseases (NOT ATD's, and not considered infectious):

Do you have:

Asthma? Y N **Allergies?** Y N **Bronchitis?** Y N

Chronic upper airway cough syndrome "postnasal drip"? Y N **Emphysema?** Y N

Gastroesophageal reflux disease (GERD)? Y N **Chronic obstructive pulmonary disease (COPD)?** Y N

Dry cough from ACE inhibitors? Y N

After reading through the questions, I declare that I have no changes from my last visit.

Initial:_________ Date:_______________ Initial:_________ Date:_______________

Initial:_________ Date:_______________ Initial:_________ Date:_______________

Initial:_________ Date:_______________ Initial:_________ Date:_______________