Patient Information Form

Today's Date_____

First Name_____ **MI**_____ **Last Name** _____**Nickname**_____

Address: Street_____ **City**_____ **State**_____ **Zip**_____

Phone: Home_____ **Work**_____ **Cell**_____

Social Security Number_____ **Date of Birth**_____

E-mail address_____

Do you consent to text message reminders? YES / NO **Driver's License #**_____

Employer_____ **Occupation**_____

Employer's Address: Street_____ **City**_____

State_____ **Zip**_____ **Phone Number**_____

Sex: □ Male □ Female **Marital Status**: □ Single □ Married □ Separated □ Divorced □ Widowed

If case of emergency, who should be notified? _____

Relationship to patient_____ **Home Phone**_____ **Mobile**_____

Is the patient a Minor? □ Yes □ No **Name of Responsible Party**_____

Date of Birth_____ **Relationship to Patient**_____

Dental Benefit Plan Information

Primary Dental Plan Name_____

Address: Street_____ **City**_____ **State**_____ **Zip**_____

Name of Subscriber_____ **Date of Birth**_____ **SSN**_____

ID/Policy Number_____ **Group Number**_____

Patient relationship to subscriber_____

Secondary Dental Plan Name_____

Address: Street_____ **City**_____ **State**_____ **Zip**_____

Name of Subscriber_____ **Date of Birth**_____ **SSN**_____

ID/Policy Number_____ **Group Number**_____

Patient relationship to subscriber_____

Whom may we thank for referring you? *Please list*

□ Current established patients

□ Website

□ Doctor

□ Advertisement

□ Website

□ Insurance Company

Please list any other members of your immediate family who are patients in our practice:

_____ _____ _____ _____

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment **Cash, Visa, MC, AMEX, and Discover.**

Dental Plan Benefits: Your dental benefit is a contract between you and/or your employer and the dental benefit plan. Benefit and payments received are based on the terms of the contract negotiated between you and/or your employer and the plan. *We are happy to help our patients with dental benefit plans to understand and maximize their coverage!*

If we ARE a contracted provider with your plan, you are responsible only for you portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductibles, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed you will be adjusted to reflect this.

If we are NOT a contracted provider with your plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursements for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we require a **48-hour notice** to reschedule an appointment. With less than a 48-hour notice, a fee of $50 or a deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may

need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50 or a deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have been given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

Initials_____

I have read the above and agree to the financial and scheduling terms.

Initials_____

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

Initials_____

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Initials_____

Signature: _____ **Date**_____

Treatment to be done:

I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional community appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there was a need for a referral to a specialist deemed necessary by my Dentist, then the cost of this referral would be my responsibility.

Initials_____

Drugs and Medications:

I understand that antibiotics, analgesics and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergy to specific medication to avoid possible adverse effects form medication that my dentist will prescribe.

Initials_____

Changes in Treatment Plan:

I understand that during treatment, it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my Dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment out-come, or eventual loss of teeth.

Initials_____

Signature:_____ **Date**_____

Dental Health History

When was the date of your last cleaning and/or dental examination?

_____

If you left your last dentist, what are the reasons for doing so?

_____

Are you experiencing any pain now? □ No □ Yes

If yes, please describe_____

Have you ever needed to pre-medicate for dental treatment? □ No □ Yes

If yes, please describe_____

Do you have any concerns and/or questions you want addressed? □ No □ Yes

If yes, please describe_____

Have you ever had orthodontic treatment? □ No □ Yes

If yes, when? _____

Have you ever had your teeth whitened? □ No □ Yes If yes, when?_____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ **Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No **Is your general health good?**
   If NO, explain _____
2. Yes / No **Has there been a change in your health within the last year?**
   If YES, explain _____
3. Yes / No **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. Yes / No **Are you being treated by a physician now?**
   If YES, explain _____

   Date of last medical exam? _____ **Reason for exam** _____
5. Yes / No **Have you had problems with prior dental treatment?**
   If YES, explain _____

   Date of last dental exam _____ **Name of last treating dentist** _____
6. Yes / No **Are you in pain now?**
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking_____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?**_____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain_____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why_____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when_____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature_____ Date_____

Physician's Name_____ Phone Number_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, (*patients name*) understand that as part of my healthcare, this facility originates and maintains health records describing my health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness

_____

Printed Name of Individual or Legal Representative

_____

Date: _____