Welcome!

Patient Information

Patient's Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

*Home Phone: _____ *Cell Phone: _____

*E-Mail Address: _____ Physician/Medical Group Name: _____

Emergency Contact: _____ Relationship: _____

Referred by: _____Friend _____Postcard _____Drive-by/Signage ____Internet ____ Other:_____

Responsible Party Information (if applicable)

Mother/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Father/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Insurance Information

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

Dental History

Date of last dental visit:_____ Dentist Name:_____

Were x-rays taken at your last visit: ☐ Yes ☐ No

Please check Yes or No to any of the following conditions that apply to you:

Y /N (Please Check)	Y /N (Please Check)	Y /N (Please Check)
☐☐ Problems Associated w/Previous Dental Treatment	☐☐ Bleeding Gums	☐☐ Grinding or Clenching Teeth
☐☐ Tooth Pain	☐☐ Food/Floss Catches between Teeth	☐☐ Earaches or Neck Pain
☐☐ Serious Injury to Head/Mouth	☐☐ Sores or Ulcers in Mouth	☐☐ Clicking/Popping/Pain in Jaw
☐☐ Dry Mouth	☐☐ Orthodontic Treatments (braces)	☐☐ Drinks Bottled or Filtered Water
☐☐ Home Water Supply Fluoridated	☐☐ Previous periodontal (gum) Treatment	☐☐ Denture/Partials
☐☐ Tooth/teeth sensitivity to cold, hot, and/or sweets	☐☐ Tooth/teeth sensitivity when chewing (pressure)	

Patient Name_____DOB_____

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 been hospitalized or visited the emergency room in the last 6 months? ☐Yes ☐No If yes, what were you treated for?_____

_____

Are you currently taking blood thinners? ☐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: _____

Have you or anyone in your family had any complications with general anesthesia? ☐Yes ☐No

Please list any and all allergies:

_____

_____

Please list all medications you are now taking:

Medication	**Dosage**	**Why**

Y /N (Please Check)

GENERAL
- ☐☐ Tire Easily, Weakness
- ☐☐ Marked Weight Change
- ☐☐ Persistent Fever
- ☐☐ Taken Steroids
- ☐☐ Bruise easily
- ☐☐ Frequent Headaches

SKIN
- ☐☐ Changes in Skin Color
- ☐☐ Rashes, Hives
- ☐☐ Shingles

EYES
- ☐☐ Eye Problems
- ☐☐ Glaucoma

EARS
- ☐☐ Loss of Hearing
- ☐☐ Ear Infections

NOSE
- ☐☐ Sinus Problems
- ☐☐ Frequent Nose Bleeds

DEVELOPMENTAL
- ☐☐ Autism
- ☐☐ ADHD
- ☐☐ Down Syndrome
- ☐☐ Spina Bifida
- ☐☐ Disabilities/ Special Needs

Y /N (Please Check)

THROAT
- ☐☐ Frequent Sore Throat
- ☐☐ Post Nasal Drip
- ☐☐ Cleft Palate

ENDOCRINE
- ☐☐ Diabetes
- ☐☐ Thyroid Problems
- ☐☐ Other Gland Problems
- ☐☐ Hypoglycemia

NERVOUS SYSTEM
- ☐☐ Stroke
- ☐☐ Emotional Problems
- ☐☐ Convulsions/Epilepsy
- ☐☐ Numbness/Tingling
- ☐☐ Dizziness/Fainting
- ☐☐ Nerve Problems
- ☐☐ Head Injury
- ☐☐ Psychiatric Treatment

BLOOD
- ☐☐ Bleeding Problems
- ☐☐ Blood Disorder
- ☐☐ Sickle Cell
- ☐☐ Anemia
- ☐☐ HIV
- ☐☐ Blood Transfusion
- ☐☐ Hepatitis

Y /N (Please Check)

CARDIOVASCULAR
- ☐☐ Mitral Valve Prolapse
- ☐☐ Rheumatic Fever
- ☐☐ Any Heart Disease
- ☐☐ High Blood Pressure
- ☐☐ Low Blood Pressure
- ☐☐ Chest Pain/Discomfort
- ☐☐ Congenital Heart Disease
- ☐☐ Artificial Heart Valve
- ☐☐ Pacemaker
- ☐☐ Scarlet Fever
- ☐☐ Heart Surgery
- ☐☐ Heart Attack
- ☐☐ Heart Murmur
- ☐☐ Irregular Heartbeat
- ☐☐ High Cholesterol

RESPIRATORY
- ☐☐ Asthma
- ☐☐ Emphysema/COPD
- ☐☐ Bronchitis
- ☐☐ Pneumonia
- ☐☐ Persistent Cough
- ☐☐ Tuberculosis

Y /N (Please Check)

MUSCULOSKELETAL
- ☐☐ Arthritis/Rheumatism
- ☐☐ Broken Bones
- ☐☐ Artificial Joints
- ☐☐ Osteoporosis

DIGESTIVE
- ☐☐ Changes in Appetite
- ☐☐ Black, Bloody or Pale Stools
- ☐☐ Jaundice
- ☐☐ Hepatitis
- ☐☐ Stomach Ulcers/Disease
- ☐☐ Liver Disease
- ☐☐ Intestinal Disease

URINARY
- ☐☐ Kidney Disease
- ☐☐ Kidney Transplant
- ☐☐ Venereal Disease
- ☐☐ Renal Dialysis

OTHER
- ☐☐ Auto-Immune Disorders
- ☐☐ Cancer
- ☐☐ Radiation Treatment
- ☐☐ Tumors/Growths

If you marked *yes* to **diabetes**, do you have Type 1 ☐ or Type 2 ☐

Have you checked your blood sugar today? Yes ☐ or No ☐ Indicate your most recent blood sugar reading_____

Indicate your most recent A1C reading _____

Date of most recent A1C reading _____

If you marked *yes* to **asthma**, is your asthma controlled? Yes ☐ or No ☐

Over

Continued:

Habits - Amounts

☐ Smoke _____ Packs ☐ Alcohol _____ Per Day

☐ Drug Use _____ Have you ever had a problem with drugs or alcohol? ☐Yes ☐No

Other _____

All Operations or Surgeries: Year

_____

_____

_____

_____

WOMEN ONLY: Are You

Pregnant/Trying to get Pregnant? ☐Yes ☐No

Nursing? ☐Yes ☐No

Taking oral contraceptives? ☐Yes ☐No

IMPORTANT: Antibiotics (Penicillin, Erythromycin, etc.) which may be prescribed after treatments, may cause the birth control pill to be ineffective. Other methods of contraception are recommended for the duration of the effected cycle.

Is there anything else you feel we should know about?

_____

_____

_____

_____

I certify that I can speak, read, and write English and have read and fully understand this medical history form. To the best of my knowledge all the preceding answers are true and correct:

Patient/Parent/ Guardian Name_____ Date_____

Patient/Parent/ Guardian Signature_____ Date_____

Provider Signature_____ Date_____

Provider Signature_____ Date_____

Informed Consent Form for General Dental Procedures

Patient Name: **Date:**

Our patients have the right to accept or refuse the recommended dental treatment proposed by their dentist. Your dentist and dental team will thoroughly communicate with you the ideal and alternative treatment options, the risks associated with both, and the risk of no treatment, before you are asked to give consent.

Do not consent to treatment unless you are satisfied with the answers conveyed to you by your dental team and all of your questions have been answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is also important that you follow your dentist's advice and recommendations regarding medications, pre- and post-treatment instructions, referrals to specialists, and the necessity to return for scheduled appointments. Failure to follow the advice and recommendations of your dentist may result in a poor treatment outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a serious heart condition, or are taking blood thinners or anticoagulants, advise your dentist immediately so he/she can consult with your physician.

In dentistry, there are commonly known risks and potential complications associated with dental treatment. No provider can guarantee the success of the recommended treatment, or that you will not experience a complication or less than an optimal result. Although these complications are rare, they can and do occur occasionally.

Medications and Sedation: I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications in the manner prescribed may increase the likelihood of continued or aggravated infection or pain, as well as the potential resistance towards future treatment of my condition. **Women:** I understand that antibiotics can decrease the effectiveness of birth control and I have been informed of this risk.

Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during the initial examination (ie. root canal therapy following routine restorative procedures). My dentist will discuss any modifications to the original treatment plan with me prior to completing treatment.

Temporomandibular Joint (TMJ) Dysfunction: I understand that symptoms of popping, clicking, locking, and pain, can intensify or develop in the joint of the lower jaw (near the ear) following routine dental treatment caused by the mouth being open for prolonged period of time. However, the symptoms of TMJ dysfunction associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

Fillings: I understand that care must be exercised in chewing on recently restored teeth during the first 24 hours to prevent breakage of the filling. I have been informed that sensitivity is a common after-effect of a newly placed filling.

I understand that dentistry is not an exact science and therefore comprehend that results cannot be guaranteed. I acknowledge that no guarantee or assurance had been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than my treating dentist is responsible for my dental treatment.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of the recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment. This form will remain in effect until terminated by either this dental office or by you.

Patient Name (Print) Date of Birth

Patient Signature Date

Witness Date

APPOINTMENT POLICY

In an effort to provide the highest quality care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your reserved appointment.

We require confirmation for all appointments. As a courtesy to our patients, a confirmation service is utilized to improve the efficiency of your ability to confirm your appointments by:

- o Email
- o Text Message
- o Phone Call

Our cancellation policy is as follows:

If a patient does not notify us 24 hours in advance that he/she will not be coming to the appointment, we will consider this a failed appointment. We understand that occasionally, circumstances arise that prevent patients from keeping appointments, thus the first failed appointment will be excused. After the second failed appointment, the patient will only be allowed to schedule appointments between the hours of 11am and 2pm. If a patient fails three appointments, we will place him/her on a short call list allowing same day appointments, which can also be requested by the patient on a same day basis only.

This system was implemented to limit the amount of last-minute cancelations/no shows due to the high demand for dental care.

We value our patient/doctor relationships and will do our best to accommodate you. Your communication and compliance are not only very much appreciated, but will allow us to assist you in achieving a positive outcome.

Thank you in advance for your cooperation. Your cooperation enables us to serve the needs of all patients.

By signing below, I acknowledge I have read and understand the **Appointment Policy**.

_____

Patient Name DOB

_____

Patient/Parent/Guardian Signature Date

We are privileged you have chosen us as your dental provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to the commencement of dental treatment. If you have any questions, please feel free to ask.

FINANCIAL POLICY

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. Also, we reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and co-payments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

At your discretion, any unpaid balance after 90 days will be sent to collections at which time the patient is responsible for any fees associated with the collection of the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Signature of Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____

Responsible Party (If different than patient): _____

Responsible Party/Patient Signature: _____

Date: _____

I hereby give my permission to discuss all aspects of my dental treatment to the individuals listed below:

☐ Mother ☐ Husband

☐ Father ☐ Wife

☐ Other (Please Specify):_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify): _____