Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ______________________

SS # ______________________

Date ______________________

PATIENT INFORMATION

Name ______________________ Birthdate ____________ Home Phone (____) ____________

Address ______________________ City ____________ State ________ Zip ________

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

E-mail ______________ Cell Phone #1 (____) ____________ Cell Phone #2 (____) ____________

Employer/School ______________________ Employer/School Phone (____) ____________

Employer/School Address ______________ City ____________ State ________ Zip ________

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 ______________________ Relation to Patient ____________

Address ______________________ Home Phone (____) ____________

Driver's License # ______________________ Birthdate ____________ Bank ____________

Employer ______________________ Work Phone (____) ____________

Currently a patient in our office? ☐ Yes ☐ No E-mail ____________ Cell Phone (____) ____________

INSURANCE INFORMATION

Name of Insured ______________________ Relation to Patient ____________

Birthdate ______________ Social Security # ____________ Date Employed ____________

Employer ______________________ Work Phone (____) ____________

Employer Address ______________ City ____________ State ________ Zip ________

Insurance Company ______________ Group # ____________ Union or Local # ____________

Address ______________ City ____________ State ________ Zip ________

How much is your deductible? ________ How much have you used? ________ Max. Annual Benefit ________

ADDITIONAL INSURANCE

Name of Insured ______________________ Relation to Patient ____________

Birthdate ______________ Social Security # ____________ Date Employed ____________

Employer ______________________ Work Phone (____) ____________

Employer Address ______________ City ____________ State ________ Zip ________

Insurance Company ______________ Group # ____________ Union or Local # ____________

Address ______________ City ____________ State ________ Zip ________

How much is your deductible? ________ How much have you used? ________ Max. Annual Benefit ________

- O V E R -

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DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ______________________

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

____

____

____

Allergies:

____

____

____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______________________ ______________________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL TREATMENT CONSENT FORM

PLEASE READ AND INITIAL THE ITEMS CHECKED BELOW
AND READ AND SIGN THE SECTION AT THE BOTTOM OF FORM

☐ 1. WORK TO BE DONE:
I UNDERSTAND THAT I AM HAVING THE FOLLOWING WORK DONE: FILLINGS_____ BRIDGES_____
CROWNS_____ EXTRACTION_____ IMPACTED TEETH REMOVED_____
ROOT CANAL_____ OTHER_____ (INITIALS__________)

☐ 2. DRUGS AND MEDICATION:
I UNDERSTAND THAT ANTIBIOTICS AND ANALGESICS AND OTHER MEDICATIONS CAN CAUSE ALLERGIC REACTIONS CAUSING REDNESS AND SWELLING OF TISSUES, PAIN, ITCHING, VOMITING, AND/OR ANAPHYLACTIC SHOCK. (INITIALS__________)

☐ 3. 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 THE TEETH THAT WERE NOT DISCOVERED DURING EXAMINATION, THE MOST COMMON BEING A ROOT CANAL THERAPY FOLLOWING ROUTINE RESTORATIVES PROCEDURES. I GIVE MY PERMISSION TO DENTIST TO MAKE ANY/ALL CHANGES AND ADDITIONS AS NECESSARY. (INITIALS__________)

☐ 4. REMOVAL OF TEETH:
ALTERNATIVES TO REMOVALS HAVE BEEN EXPLAINED TO ME (ROOT CANAL, CROWNS, AND PERIODONTAL SURGERY.) AND AUTHORIZE THE DENTIST TO REMOVED THE FOLLOWING TEETH __________________ AND ANY OTHER NECESSARY FOR REASONS IN PARAGRAPH #3. I UNDERSTAND REMOVING TEETH DOESN'T ALWAYS REMOVED ALL THE INFECTION IF PRESENT, AND IT MAY BE NECESSARY TO HAVE FURTHER TREATMENT. I UNDERSTAND THE RISK INVOLVED IN HAVING TEETH REMOVED, SOME OF WHICH ARE PAIN, SWELLING, SPREAD OF INFECTION, DRY SOCKET, LOSS OF FEELING IN MY TEETH, LIPS, TONGUE, AND SURROUNDING TISSUE (PARATHESIA) THAT CAN LAST FOR INDEFINITE PERIOD OF TIME (DAYS OR MONTHS) OR FRACTURED JAW. I UNDERSTAND I MAY NEED FURTHER TREATMENT BY A SPECIALIST. OR HOSPITALIZATION IF COMPLICATIONS ARISE DURING OR FOLLOWING TREATMENT THE COST OF WHICH IS MY RESPONSIBILITY. (INITIALS__________)

☐ 5. CROWNS BRIDGES AND CAPS:
I UNDERSTAND THAT SOMETIMES IT IS NOT POSSIBLE TO MATCH THE COLOR OF NATURAL TEETH EXACTLY WITH ARTIFICIAL TEETH. I FURTHER UNDERSTAND THAT I MAY BE WEARING TEMPORARY CROWNS WHICH MAY COME OFF EASILY AND THAT I MUST BE CAREFUL TO INSURE THAT THEY ARE KEPT ON UNTILL THE PERMANENT CROWNS ARE DELIVERED. I REALIZE THE FINAL OPPORTUNITY TO MAKE CHANGES IN MY NEW CROWN, BRIDGE OR CAP (INCLUDING SHAPE, SIZE, FIT AND COLOR) WILL BE BEFORE CEMENTATION. (INITIALS__________)

☐ 6. DENTURES. COMPLETE OR PARTIALS
I REALIZE THAT FULL OR PARTIAL DENTURE ARE ARTIFICIAL, CONSTRUCTED OF PLASTIC, METAL, AND/OR PORCELAN. THE PROBLEMS OF WEARING THESE APPLIANCES HAVE BEEN EXPLAINED TO ME INCLUDING LOOSENESS, SORENESS, AND POSSIBLE BREAKAGE. I REALIZE THE FINAL OPPORTUNITY TO MAKE CHANGES IN MY NEW DENTURE (INCLUDING SHAPE, FIT, SIZE, PLACEMENT, AND COLOR) WILL BE THE "TEETH IN WAX" TRY IN VISIT. I UNDERSTAND THAT MOST DENTURE REQUIRE RELINING THREE TO TWELVE MONTHS AFTER INITIAL PLACEMENT. THE COST FOR THIS PROCEDURE IS NOT INCLUDED IN THE INITIAL DENTAL FEE. (INITIALS__________)

☐ 7. ENDODONICS TREATMENT (ROOT CANAL):
I REALIZE THAT THERE IS NO GUARANTEE THAT ROOT CANAL TREATMENT WILL SAVE MY TOOTH, AND THAT OCCASIONALLY METAL OBJECTS ARE CEMENTED IN THE TOOTH OR EXTEND THROUGH THE ROOT. WHICH DOES NOT NECESSARILY AFFECT THE SUCCESS OF THE TREATMENT. I UNDERSTAND THAT OCCASIONALLY ADDITIONAL SURGICAL PROCEDURE MAYBE NECESSARY FOLLOWING THE ROOT CANAL TREATMENT (APICOECTOMY).

☐ 8. PERIODONTAL LOSS (TISSUE & BONE)
I UNDERSTAND THAT I HAVE A SERIOUS CONDITION CAUSING GUM AND BONE INFECTION OR LOSS AND THAT IT CAN LEAD TO THE LOSS OF MY TEETH. ALTERNATIVE TREATMENT PLANS HAVE BEEN EXPLAINED TO ME. INCLUDING GUM SURGERY, REPLACEMENT AND/OR EXTRACTIONS. I UNDERSTAND THAT UNDERTAKING ANY DENTAL PROCEDURES MAY HAVE A FUTURE ADVERSE AFFECT ON MY PERIODONTAL CONDITION. (INITIALS__________)

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THAT THEREFORE REPUTABLE PRACTITIONERS CANNOT FULLY GUARANTEE RESULTS. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE BY ANYONE REGARDING THE DENTAL TREATMENT, WHICH I HAVE REQUESTED AND AUTHORIZE. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM AND ASK QUESTIONS. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO THE PROPOSED TREATMENT.

SIGNATURE OF PATIENT____ DATE______________

SIGNATURE OF PARENT OR GUARDIAN________________________________ DATE______________

(NAME OF PRACTICE)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to sign This Acknowedgement *

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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