|  |
| --- |
| **Patient Information** |
| [ ] New Patient | [ ] Update |  |  | Date: |  |  |
| Patient: |  |  |  |  |  |  |
|  | Last | First | MI | Preferred | Title |  |
|  | [ ] Male [ ] Female | [ ] Child\* [ ] Student\*\* | [ ] Single [ ] Married [ ] Divorced [ ] Widowed |
|  |
| \*If Child, provide parent/guardian name(s) below: | \*\*If Student, please complete: [ ] Full-time [ ] Part-Time |  |
|  |  |  |  |  |  |
|  | Parent/Guardian Name(s) |  |  | School/Location |  |
|  |
| Patient Date of Birth: |  | Patient SSN: |  |  |
| Address: |  |  |  |
|  | Address Line 1 |  |  |  |
|  |  | Home: |  |  |
|  | Address Line 2 | Cell: |  |  |
|  |  |  |  | Other: |  |  |
|  | City | State | ZIP Code | Preferred method of communication:  |
| E-Mail: |  | [ ]  Home [ ]  Cell [ ]  Other |  |
| Referral? | [ ] Yes [ ]  No | **Referred by:** |  |  |
|  |

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| **emergency Information** |
| In case of emergency, please provide information for the nearest relative or designated contact person not at the patient’s address: |
|  |  |  | Tel: |  |  |
|  | Name | Relationship |  |  |  |

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| **employment Information** |
| Employer: |  | Occupation: |  |  |
| Address: |  |  |  |
|  | Address Line 1 | Work: |   |  |
|  |  | Direct: |  |  |
|  | Address Line 2 | Other: |  |  |
|  |  |  |  | Pager: |  |  |
|  | City | State | ZIP Code | Fax: |  |  |
|  |

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| --- | --- | --- |
| **PRIMARY insurance Information**  |  | **SECONDARY insurance Information** |
| Subscriber |  |  | Subscriber |  |
|  | Last, First, Middle Initial |  |  | Last, First, Middle Initial |
| Subscriber DOB |  |  | Subscriber DOB |  |
| Subscriber SSN |  |  | Subscriber SSN |  |
| Subscriber Employer |  |  | Subscriber Employer |  |
| Patient Relationship to Subscriber | [ ] Self [ ] Spouse [ ] Child  |  | Patient Relationship to Subscriber | [ ] Self [ ] Spouse [ ] Child  |
| [ ] Other |  | [ ] Other |  |
| Insurance Carrier |  |  | Insurance Carrier |  |
| Group/Policy No. |  |  | Group/Policy No. |  |
| Identification No. |  |  | Identification No. |  |
| Insurance Address |  |  | Insurance Address |  |
|  |  |  |  |  |
| Telephone Number |  |  | Telephone Number |  |
|  |  |  |  |  |

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| **Previous Dentist Information** |
| Dentist: |       | Telephone: |       |  |
| Address: |       |  |
|  |       |       |       |  |
|  | City | State | ZIP Code |  |
| Reason for changing: |       |  |
|  |

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| --- |
| **dental history** |
| Oral Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor | Date of last dental visit: |       |  |
| Last regular cleaning: |       | Treatment type:  |       |  |
|  |  |  |  |  |
|  |
| [ ] Y [ ] N | Are you currently having dental discomfort? If yes, explain: |       |  |
| [ ] Y [ ] N | Any unhappy/unpleasant dental experiences? If yes, explain: |       |  |
| [ ] Y [ ] N | Any injuries to mouth/teeth/head? If yes, explain: |       |  |
| [ ] Y [ ] N | Any missing teeth other than wisdom teeth or orthodontic extractions? |  |
| [ ] Y [ ] N | Have missing teeth been replaced? |  |
| [ ] Y [ ] N | Do you have any mercury/silver amalgam fillings?  |  |
| [ ] Y [ ] N | Received root canal therapy? |  |
| [ ] Y [ ] N | Orthodontic appliances now or in the past? |  |
| [ ] Y [ ] N | Gums bleed when brushing or flossing? |  |
| [ ] Y [ ] N | Concerned about gum disease? History of gum disease? [ ] Y [ ] N |  |
| [ ] Y [ ] N | Any concerns about the appearance of your teeth? |  |
| [ ] Y [ ] N | Does it hurt to bite or chew? |  |
| [ ] Y [ ] N | Does food catch between your teeth? |  |
| [ ] Y [ ] N | Do you have tooth sensitivity to heat, cold, pressure or sweets? |  |
| [ ] Y [ ] N | Do you have pain or clicking in the jaw joint in front of your ear? |  |
| [ ] Y [ ] N | Have your jaw muscles ever been sore? |  |
| [ ] Y [ ] N | Are there any sores or growths in your mouth? |  |
| [ ] Y [ ] N | Do any of your teeth ache? |  |
| [ ] Y [ ] N | Teeth shifted, new spaces between teeth, teeth flaring or loose teeth? |  |
| [ ] Y [ ] N | Do you clench or grind your teeth? If so, do you wear a night guard or splint? [ ] Y [ ] N |  |
| [ ] Y [ ] N | Do you want to become a regular continuing care patient in our practice? |  |
| [ ] Y [ ] N | Do you want your mouth properly restored and pain free? |  |
| [ ] Y [ ] N | Does any type of dental treatment make you nervous? If yes, please explain below: |  |
|  |  |       |  |
| The most important concerns regarding my dental treatment are: |       |  |
|  |       |  |
| What factors are most important for your satisfaction with our office? |       |  |
|  |       |  |
| Any additional concerns/comments? |       |  |
|  |       |  |
|  |       |  |
|  |       |  |
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| **primary physician Information** |
| Physician: |       | Telephone: |       |  |
| Clinic/Facility: |       |  |
|  |  |  |

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| **Medical History** |
| General Health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor |
| [ ] Y [ ] N | Under a physician’s care now? |  |
| [ ] Y [ ] N | Any hospitalization in the past 5 years? |       |  |
| [ ] Y [ ] N | Any serious illnesses/surgeries? |       |  |
| [ ] Y [ ] N | Use tobacco in any form? If Yes, Type: |       |  |
| [ ] Y [ ] N | Is pre-medication required before dental visits due to heart condition or artificial joint? |  |
| [ ] Y [ ] N | Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.* |  |
| [ ] Y [ ] N Do you know of any reason why routine dental procedures might pose a risk to you, our staff or other patients?  |
|  | If yes, please describe:  |       |  |
|  |
| Is there anything important about your medical condition we have not asked? [ ] Y [ ] N If yes, please describe: |
|  |       |  |
|  |  |  |
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|  |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): |
| [ ]  No Allergies | [ ]  Food Additives/Dyes | [ ]  Morphine | [ ] Other – please list: |  |
| [ ]  Anesthetic – Local | [ ]  Keflex | [ ]  Penicillin/Other Antibiotics |  |  |
| [ ]  Aspirin | [ ]  Latex | [ ]  Sulfa Drugs |  |  |
| [ ]  Codeine | [ ]  Metal Sensitivity | [ ]  Tylenol |  |  |
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| **medication information** |
| All Patients: Are you currently taking any of the following? (Check all that apply): |  |
| [ ]  Antibiotics/Sulfa Drugs | [ ]  Cancer/Chemo Meds | [ ]  Insulin | [ ]  Osteoporosis Meds |
| [ ]  Antihistamines/Allergy | [ ]  Cortisone/Steroids | [ ]  Nitroglycerin | [ ]  Recreational Drugs |
| [ ]  Blood pressure Meds | [ ]  Daily Aspirin | [ ]  Oral Contraceptives | [ ]  Thyroid Meds |
| [ ]  Blood thinners | [ ]  Heart Medication/Digitalis | [ ]  Other Diabetic Meds | [ ]  Tranquilizers |
| [ ]  Other (please list below) |  |  |  |
|  |
| **Drug Name** | **Dosage** | **Reason Prescribed** |
|       |       |       |
|       |       |       |
|       |       |       |
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|  **Review of Medical systems** |
| Please check any of the items below that pertain to you. |
| **General** |  | **Pulmonary** |  | **Musculoskeletal** |  | **Endocrine** |
|  | Recent weight loss |  |  | Pneumonia/Pleurisy |  |  | Pain in joints/arthritis |  |  | Diabetes |
|  | Chronic fatigue |  |  | Respiratory disease |  |  | Pain in muscles |  |  | Thyroid problems |
|  | Anemia |  |  | Breathing problems |  |  | Recurrent back pain |  |  | Excessive thirst  |
|  |  |  |  | Excessive snoring |  |  | Past injury to bones, spine, joints or head |  |  | Low blood sugar |
| **Eyes** |  |  | Asthma/Wheezing |  |  |  | Intolerance to heat/cold |
|  | Failing vision |  |  | Tuberculosis  |  |  | Gout attacks |  |  | Feet and hands numbness/pain |
|  | Eye pain |  |  |  |  |  | Artificial joints |  |
|  | Double vision |  | **Gastrointestinal**  |  |  |  |  |  |  |
|  | Blurred vision |  |  | Heartburn/Acid Reflux  |  | **Integumentary** |  | **Substance/Chemical Use** |
|  | Glasses/contacts |  |  | Persistent nausea/vomiting |  |  | Cancer / Tumors  |  |  | More than 6 drinks/wk |
|  | Radial Keratotomy/Lasik |  |  | Chronic abdominal pain |  |  | Autoimmune disease |  |  | Use of tobacco  |
|  |  |  |  | Special diet |  |  | Skin rashes/Hives |  |  | Caffeine use |
| **Ears, Nose, Mouth** |  |  | Diarrhea/IBS  |  |  | Skin moles-black or changing |  |  | Over-the-counter medicine / vitamins |
|  | Facial Pain |  |  | Stomach/Intestinal Disease |  |  |  |  |
|  | Decreased hearing |  |  | Constipation |  | **Neurologic** |  |  |  |
|  | Ringing in ear/Tinnitus |  |  | Ulcers |  |  | Frequent headaches |  | **Additional Questions** |
|  | Fullness/Plugging |  |  |  |  |  | Autism/Asperger’s |  |  | Liver problems |
|  | Frequent ear infections |  | **Cardiovascular** |  |  | Numbness/tingling |  |  | Hepatitis |
|  | Vertigo |  |  | Heart attack/disease |  |  | Seizures/convulsions |  |  | Radiation/Chemo |
|  | Frequent nose bleeds |  |  | Chest pain |  |  | Epilepsy/stroke |  |  BMI |  |
|  | Sinus trouble |  |  | Pace maker |  |  | Difficulty sleeping |  |  |
|  | Frequent sore throats |  |  | Excessive bleeding |  |  | Tourette’s/Movement Disorder |  | **Neck** |
|  | Swallowing problems |  |  | Bleeding disorder |  |  | Memory loss |  |  | Lumps |
|  | Sore tongue  |  |  | Congenital heart disease |  |  | ADHD |  |  | Swollen glands |
|  | Bleeding gums |  |  | Mitral valve prolapse |  |  |  |  |  | Pain |
|  | Tooth or jaw pain |  |  | Artificial heart valve |  | **Psychological** |  |  | Stiffness |
|  | Frequent cold sores |  |  | Heart surgery |  |  | Feeling depressed |  |  | Thyroid problems |
|  | Tooth pain |  |  | Dizzy spells |  |  | Nervous or anxious |  |  |
|  |  |  |  | Angina |  |  | Difficulty concentrating |  | **Women Only** |
| **Genito-Urinary** |  |  | Fainting spells |  |  | Insomnia |  |  | Pregnant |
|  | Kidney disease |  |  | High/Abnormal Blood Pressure |  |  | Phobias/unexplained fears |  |  | Nursing |
|  | Any venereal disease in the past? (Herpes, Chlamydia, gonorrhea) |  |  | Rheumatic fever |  |  | Psychiatric treatment |  | Due Date |  |
|  |  | Heart murmur/Palpitations |  |  |  |  |  |  |
|  |  |  |  | Shortness of breath |  | **Hematologic/Lymphatic** |  | **Final Review** |
| **Allergic/Immunologic** |  |  | Swollen ankles |  |  | Excessive bruising  |  |  | I have reviewed this |
|  | Hay fever / Allergies |  |  |  |  |  | Excessive bleeding |  | Initials | form. None of the |
|  | Recurrent infections |  |  |  |  |  | Swollen glands-neck, armpit or groin  |  |  | above apply to me. |
|  | HIV or AIDS |  |  |  |  |  |  |  |

**Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total health.
In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

**Insurance**

**We accept all major dental insurance payments, however we may not be an in network provider for your plan**. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

* **We will assist our patients in filing insurance claims through any benefit company that allows your choice of provider.** As part of our legal agreements, the dental insurance plan administrators require that we offer no additional discounts and collect co-payment at the time of service.
* We also offer a **discounted health care services plan** for our patients that do not have a dental benefit plan.
* **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

**Payments**

**Patient portion or** **patient co-payment is due at** **the time services are rendered** - unless prior financial arrangements have been made.

* **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.
* All major credit cards are accepted (Visa, MasterCard, Discover)
* 5% Discount for our uninsured patients who pay by cash/check.
* 5 % Discount for our uninsured senior patients age 62 and above who pay by cash cash/check.
* Various financing options with CareCredit®

**Short Cancelled/ Missed Appointments**

* **Please give a minimum 48 hour notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments and we appreciate the same courtesy from you.
* **Late, cancelled or missed appointments may be subjected to a minimum fee of $25 based on length of time reserved**. If you are late, cancel or miss more than two appointments without notice in a 6-month period, you will be required to place a deposit in order to secure your appointment time.

**By signing below I acknowledge I have read and understand the guidelines above.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |

**Relationship to Patient**: [ ] Adult Patient [ ] Parent [ ] Guardian [ ] Other

**Please list any dependent children under the age of 18 also covered by this acknowledgement:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
| In addition to the entities mentioned in the Notice of Privacy Practices, I authorize Synergy Dental Solutions to release my health information to the following individuals: |
|  |  |  |  |  |
| Name |  | Relationship |  | Contact |
|  |  |  |  |  |
| Name |  | Relationship |  | Contact |
|  |  |  |  |  |
| Name |  | Relationship |  | Contact |
|  |

[ ]  I give permission for the following communications to be used by Dr. Angela Tenholder, DMD **(please check all that apply)** :

 [ ]  Cell phone: [ ] Text Message reminders permitted
 [ ]  Home phone [ ]  Work [ ]  E-Mail:

[ ]  I am granting permission for Angela Tenholder, DMD to disclose their identity to anyone who may answer my home, work or cell phone.

[ ]  I am granting permission for Angela Tenholder, DMD to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

 [ ]  Home Phone [ ]  Cell Phone [ ]  Work Phone [ ]  None- please just ask for a call back
 [ ]  Other (Please explain)

**I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments,
treatment, and billing of myself and any dependent children listed above:**

|  |
| --- |
| **For Office Use Only:** |
| We were unable to obtain the patient’s written acknowledgement of our Notice of Privacy Practices due to the following reason:[ ]  The patient refused to sign[ ]  Communication barriers [ ]  Emergency situation |
| [ ]  Other – please list: |       |

|  |
| --- |
| **Patient consent- payment authorization – signature on file** |
|  |
| To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.I hereby authorize payment directly to Dr. Angela Tenholder of the dental benefits otherwise payable to me.I hereby authorize Dr. Tenholder to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. **By signing below, I acknowledge that I have read and understand the statements mentioned above.** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Print Name |  | Date |  |
|  |  |  |  |
| Signature |  |  |  |