Patient Information Form

Today's Date _____

Patient Name: First _____ MI_____ Last _____ Nickname _____

Address: Street_____City_____State_____Zip_____

Phone: Home_____Work_____Mobile_____

Social Security Number _____ **Date of Birth** _____

Drivers License # _____**State**_____

Patient Employed By_____Occupation_____Phone _____

Address:Street_____City_____State _____ Zip _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified?_____

Relationship to Patient _____Home Phone _____ Mobile Phone_____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No

Name of School _____

Name of Responsible Party: First _____Last_____

Date of Birth _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)*Street_____City_____State_____Zip _____

Phone: Home_____ Work Mobile _____

Employer *(if different from above)*_____ Occupation_____ Phone _____

Address: Street_____ City_____ State_____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name_____Phone_____

Address: Street_____City_____State_____Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address: Street _____City _____ State_____ Zip _____

Name of Insured _____ Date of Birth _____

ID Number Policy Number _____**Patient Relationship to Insured** _____

Medical Plan Information

Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ **Patient Relationship to Insured** _____ Deductible Amount _____

Whom may we thank for referring you?

☐ One of our valued patients (name of patient)_____ ☐

Advertisement_____ ☐ Local Dental Society _____ ☐ Our

Website _____ ☐ Other _____

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

_____ _____ _____

_____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with 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, Check, Credit Card** **Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

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

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, 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 to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit 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 reimbursement 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 do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of **$150.00**or 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 **$150.00** or deposit to reserve the appointment time again, may be required.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Authorizations: I understand that the information I have 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. _____(initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

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. YES / NO (Circle One) _____(initial)

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. _____(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____(initial)

Signature _____ Date_____

Dental Health History Form

Today's Date _____

Patient Name: First _____ **MI** ____ **Last** _____ **Nickname** _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) _____

Former Dentist _____ **Phone** _____

Address: Street _____ **City** _____ **State** _____ **Zip** _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain

If yes, please describe _____

Have you ever been pre-medicated for dental treatm

If yes, why? _____

Have you been anxious about having dental treatm

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? (check all that apply)

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old crowns
- ☐ Speech problems
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food gets caught in between teeth
- ☐ If yes, where? _____
- ☐ Difficulty chewing
- ☐ If yes, where? _____
- ☐ Bad breath
- ☐ Other _____

Have you ever had orthodontic treatm

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surg

If yes, when? _____

Have you whitened your teeth in the p

If yes, what method? _____

Are you interested in learning more about the following? (check all that apply)

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth-colored fillings
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At-home oral hygiene care
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers

Today's Date _____

Confidential Health History Form

Patient Name: First _____ MI _____ Last _____Date of Birth_____

Choose appropriate answer *(Leave blank if you do not understand the question)*

Is your general health good?

If NO, explain _____

Has there been a change in your health within the last year?

If YES, explain _____

Have you gone to the hospital or emergency room or had a serious illness in the last three years?

If YES, explain _____

Are you being treated by a physician now?

If YES, explain _____

Date of last medical exam? _____ **Reason for exam** _____

Have you had problems with prior dental treatment?

If YES, explain _____

Date of last dental exam _____**Name of last treating dentist** _____

Are you in pain now?

If YES, explain _____

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

- **Chest pain (angina)**
- **Fainting spells**
- **Recent significant weight loss**
- **Fever**
- **Night sweats**
- **Persistent cough**
- **Coughing up blood**
- **Bleeding problems**
- **Blood in urine**
- **Blood in stools**
- **Diarrhea or constipation**
- **Difficulty urinating**
- **Ringing in ears**
- **Headaches**
- **Dizziness**
- **Blurred vision**
- **Bruise easily**
- **Frequent vomiting**
- **Jaundice**
- **Dry mouth**
- **Excessive thirst**
- **Difficulty swallowing**
- **Swollen ankles**
- **Joint pain or stiffness**
- **Shortness of breath**
- **Sinus problems**
- **Frequent urination**

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

- **Heart disease**
- **Family history of heart disease**
- **Heart attack**
- **Artificial joint**
- **Stomach problems or ulcers**
- **Heart defects**
- **Heart murmurs**
- **Rheumatic fever**
- **Skin disease**
- **Hardening of arteries**
- **High blood pressure**
- **Seizures**
- **Cosmetic surgery**
- **Surgeries**
- **Hospitalization**
- **Diabetes**
- **Family history of diabetes**
- **Tumors or cancer**
- **Chemotherapy**
- **Radiation**
- **Arthritis, rheumatism**
- **Emphysema or other lung disease**
- **Kidney or bladder disease**
- **Stroke**
- **Eating disorders**
- **Osteoporosis**
- **Thyroid disease**
- **Asthma**
- **Hepatitis**
- **Sexual transmitted disease**
- **Herpes**
- **Canker or cold sores**
- **Anemia**
- **Liver disease**
- **Eye disease**
- **Transplants**

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

- **AIDS**
- **Anxie**
- **Depression**
- **Treatment for emotional conc**
- **Tuberculosis**

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

- **Aspirin**
- **Darvon**
- **Codeine**
- **Latex**
- **Local anesthetic (Novocain (Xylocaine)**
- **Valium**
- **Demerol**
- **Penicillin**
- **Food**
- **Erythromycin**
- **Tetracycline**
- **Vicodin**
- **Percodan**
- **Nitrous oxide**
- **Metal**

Others _____

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

- **Recreational drugs**
- **Over-the-counter medicines**
- **Weight loss medications**
- **Cortico - Steroids**
- **Bisphosphonate (Fosamax)**
- **Antibiotics**
- **Supplements**
- **Aspirin**
- **Tobacco in any form**
- **Alcohol**

Please list all medications you are currently taking_____

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

Are you or could you be pregnant? If YES, what month?_____

Are you nursing?

Are you taking birth control pills?

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

Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, explain_____

Have you ever been pre-medicated for dental treatment?

If YES, why_____

Have you ever taken Fen-Phen?

If YES, when_____

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

Physician's Name

Date: _____

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.

Patient Signature

Date: _____

Changes to Health History_____ Dentist Initials_____