Contact Information

PATIENT:

Patient Name: _____ _____
First Last

Date of Birth: _____ **Gender:** ____ Male ____ Female

Home Address: _____

_____
City State Zip Code

Email: _____

WE REQUIRE 3 PHONE NUMBERS TO CONFIRM APPOINTMENTS & FOR EMERGENCIES:

Preferred: ( ) _____ — _____ (◎ Cell, ◎ Home, ◎ Work)

Alternate: ( ) _____ — _____ (◎ Cell, ◎ Home, ◎ Work)

Emergency: ( ) _____ — _____ (◎ Cell, ◎ Home, ◎ Work)

Emergency Contact Name (Relation): _____

May We TEXT Your Cell Phone To Confirm Your Appointment? ◎ YES ◎ NO

May We EMAIL You To Confirm Your Appointment? ◎ YES ◎ NO

INSURANCE:

Dental Insurance Company: _____

Dental Insurance Phone #: ( ) _____ — _____

Dental Insurance Address: _____

Name of Insured: _____

Date of Birth of Insured: _____

Insured Member ID or Social Security # of Insured: _____

Insurance Group #: _____

Employer Name: _____

Employer Phone #: ( ) _____ — _____

Medical History

Name: _____ **Date of Birth:** _____

PLEASE PRINT. ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N).

***MEDICAL UPDATE*:**

1. Are you in good health: Y / N
2. Changes in your health in the past year: Y / N
3. Date of last medical exam: _____
4. Height: _____ , Weight: _____

***MEDICAL CONDITIONS*:** Do you have or have ever had?

Asthma	Y / N	Hepatitis B	Y / N
Emphysema	Y / N	Hepatitis C	Y / N
Tuberculosis	Y / N	HIV, AIDS	Y / N
Diabetes or High Blood Sugar	Y / N	Bleeding Disorders	Y / N
Seizures	Y / N	Gastroesophageal Reflux (GERD)	Y / N
High Blood Pressure	Y / N	Implants (Heart Valve, Pacemaker)	Y / N
Heart Attack	Y / N	Artificial Joint (Hip, Knee)	Y / N
Heart Murmur	Y / N	Arthritis	Y / N
Congenital Heart Disease	Y / N	Jaw Pain, Clicking or Popping	Y / N
Rheumatic Fever	Y / N	Back or Neck Pain	Y / N
Stroke	Y / N	Chronic Headaches	Y / N
Thyroid Disease	Y / N	Anxiety	Y / N
Kidney Disease	Y / N	Bipolar Disorder	Y / N
Cancer	Y / N _____	Depression	Y / N
Surgeries	Y / N _____	Other: _____	

FEMALES:

Currently Pregnant: Y / N _____
Planning a Pregnancy Y / N _____
Currently Nursing Y / N _____

***TOBACCO*:**

Smokes Cigarettes: Y / N (____ Pack/Day) Chew Tobacco: Y / N

***MEDICATIONS*:** Prescription or Over the Counter

***ALLERGIES*:**

Local Anesthetics	Y / N	Aspirin, Acetaminophen, or Ibuprofen	Y / N
Latex Rubber	Y / N	Penicillin or other antibiotics	Y / N
Metal Alloys (Nickel, Gold)	Y / N	Other: _____	

I understand the importance of an accurate medical history to assist the doctor in providing the best care possible. I will have the opportunity to discuss my confidential medical history with the doctor.

Patient's Signature: _____ **Date:** _____

Dental History

Name: _____ **Date of Birth:** _____

***ORAL HYGIENE*:**

◎ Do Not Brush
◎ Brush 1x/Day
◎ Brush 2x/Day

◎ Do Not Floss
◎ Floss Occasionally (____ x week)
◎ Floss ____ x/Day

***DENTAL CONDITIONS*:**

1. Please Describe Your Chief Dental Concern Today: _____
2. When Was Your Last Dental Exam? Month: _____ , Year: _____
3. Do You Have Any Missing or Broken Teeth? _____
4. Are Your Teeth Sensitive to Hot, Cold or Pressure? _____
5. Do You Have a Toothache? _____
6. Do Your Gums Bleed on Brushing or Flossing? _____
7. Do You Have Any Loose Teeth? _____
8. Do You Have a Family History of Tooth Loss or Gum Disease? _____
9. Do You Feel You Have Bad Breath? _____
10. Do You Have Any Sores or Lumps in or Near Your Mouth? _____
11. Do You Grind Your Teeth or Clench Your Jaws? _____
12. Do You Have Jaw Pain, Clicking or Popping? _____
13. Have You Ever Had a Dental Restoration (Filling, Veneer, Crown) Break After it was Placed? _____
14. Do You Have Any Allergies to Metals in Dental Restorations (Silver, Gold)? _____
15. Have Your Ever Had Orthodontic Treatment (Braces)? _____
    If You Had Braces, Are You Currently Using Retainers Regularly? _____
16. Do You Have Any Spaces or Gaps Between Your Teeth? _____
17. Have You Ever Whitened Your Teeth? _____

I understand the importance of an accurate dental history to assist the doctor in providing the best care possible. I will have the opportunity to discuss my confidential dental history with the doctor.

Patient's Signature: _____ **Date:** _____

Artisan Smiles
4 Rockbourne Rd., Suite 400 Clifton Heights, PA 19018 Tel: (484) 461-0128

Dental Procedures Informed Consent

Name: _____ **Date of Birth:** _____

While recognizing the benefits of a pleasing smile & teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, have some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Some common risks & complications associated with virtually any dental procedure, including:

1. **Drug or Chemical Reaction:** Dental materials & medications may trigger allergic reactions or adverse effects.
2. **Long Term Numbness (Paresthesia):** Local anesthesia, or it's administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or Joint Tenderness:** Holding one's mouth open can result in muscle or jaw tenderness, or in a predisposed patient, precipitate a Temporomandibular Joint (TMJ) Disorder.
4. **Sensitivity** in teeth or gums.
5. **Infection, Delayed Healing,** or **Bleeding**.
6. **Swallowing or Inhaling** small objects.

While we follow procedural guidelines, which most often lead to a clinical success, just like in any other pursuit in healthcare, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you in your treatment plan.

A new set of complete dental radiographs (x-rays) will be required for all new patients having a comprehensive oral evaluation. Dental radiographs dated less than 6 months may be used to establish a dental history, if no recent changes have occurred.

Many patients benefit from being sedated while undergoing dental treatment. The treatment rooms are continuously monitored with video surveillance. The recorded color video images are archived & remain confidential.

I the undersigned, have read the above statements and been informed of the information outlined in this consent for clinical dental procedures. I fully understand the risks & benefits, alternative treatments, if any, to this form of treatment, & no treatment. All of my questions & concerns have been satisfactorily answered & addressed. I give my consent to Artisan Smiles for dental treatment & video surveillance in the treatment rooms.

Patient's Signature: _____ **Date:** _____

OPTIONAL:

During your dental exams & procedures, we sometimes take photographs of your teeth, gums & surrounding soft tissue with a small pen sized oral camera. **This is a great form of communication between doctor & patient. A picture is worth a thousand words! Often, other examples are necessary to show a new patient what can be accomplished successfully.** Many new patients benefit from learning about the success of clinical dental procedures performed on previous patients. Your consent below will help both you & many others in sharing the possibilities.

Thank You!

I consent that all previous, new & future dental radiographs (x-rays) & oral/facial photographs that are part of my patient record may be shown in print or electronic format for educational &/or promotional purposes. All pertinent patient information will remain anonymous & confidential. I do not expect compensation, financial or otherwise, for the use of these x-rays & photographs.

Patient's Signature: _____ **Date:** _____

Notice of Privacy Practices

Acknowledgment of Receipt

Patient's Name: _____ **Date of Birth:** _____

The *Notice of Privacy Practices* provides information about how we may use & disclose your protected health information. Please review it carefully.

I acknowledge that I was provided with a copy of the currently effective "Notice of Privacy Practices" for Artisan Smiles, according to the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Patient's Signature: _____ **Date:** _____

For Patient's Personal Representative Only

If completed by a Patient's Personal Representative, please print & sign your name in the space below.

Personal Representative _____

Personal Representative's Signature _____

Relationship _____

For Office Use Only

Complete this section if this form is not signed & dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of Artisan Smile's *Notice of Privacy Practices*, but was unable to for the following reason:

◎ Patient Refused to Sign

◎ Patient Unable to Sign

◎ Other

Employee Name: _____ Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the riglit to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we leave a message on your answering machine at home or on your cell phone regarding financial matters such as: copays, deductibles or uncovered benefits?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____