Dr. Lindsey Clark-Fass, DDS, PC

CONFIDENTIAL

PATIENT INFORMATION

Please print:

Name:_____ SS#:_____ Birthday:_____

Home#:_____ Cell#:_____ Work#:_____

Address:_____ City/State/Zip:_____

E-mail address:_____

Check the appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Patient or parent's employer: _____ Address:_____

Spouse or parent's name: _____ Employer:_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY/DENTAL INSURANCE INFORMATION (please provide insurance card)

Person responsible for this account: _____ Birthday: _____SS#:_____

Employer/Address: _____ Phone#:_____

Insurance company/Address: _____ Group#:_____

What is your deductible? $_____ Max. annual benefit: $_____ How much have you used? $_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐Yes ☐No

*If **yes**, complete the following:*

Name of secondary insured: _____ Birthday: _____ SS#:_____

Employer/Address: _____ Phone#:_____

Insurance company/Address: _____ Group#:_____

What is your deductible? $_____ Max. annual benefit: $_____ How much have you used? $_____

IN THE EVNET OF EMERGENCY

Whom should we contact? _____ Relationship to patient: _____

Home#:_____ Cell#:_____ Work#:_____

Who is your medical doctor? _____ Doctor's phone#:_____

DISCLAIMER

•I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office). I fully understand that I am solely responsible for any balance not paid by my insurance company.

•I also authorize the provider to release any information to process insurance claims.

•I fully understand that payment for services rendered is to be paid at the time of service, unless other arrangements have been previously made with the business manager. If my account is not paid in full within 90 days of the date of service and no financial arrangements have been made, I understand that I am responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting my account balance.

Patient/Guardian signature: _____ Date:_____

PATIENT DENTAL HISTORY

Reason for today's visit: ☐Cleaning ☐Consultation ☐Emergency ☐Exam ☐ Other: _____
Are you currently in pain? ☐No ☐Yes If ***yes***, when did the pain begin? _____

Please indicate ☑ any of the following problems or concerns:

☐ Bad breath	☐ Locking jaw	☐ Ringing in ears
☐ Blisters/sores in the mouth	☐ Lost or broken filling(s)	☐ Sensitive teeth or gums
☐ Broken/chipped teeth	☐ Red/swollen/bleeding gums	☐ Teeth clenching/grinding
☐ Discomfort/popping/clicking in jaw	☐ Other: _____	

Previous dentist name: _____ Phone#:_____
Date of last dental visit: _____ Date of last dental x-rays: _____
How many times *per day* do you brush? _____ How many times *per week* do you floss? _____
What type of toothbrush do you use? ☐ Manual ☐ Electric ⟶ ☐ Soft ☐ Medium ☐ Hard
How would you rate your smile? (best) 10 9 8 7 6 5 4 3 2 1 (worst)

MEDICAL HISTORY

Are you taking any of the following? ☐Blood thinners (including aspirin/fish oil) ☐Insulin ☐Muscle relaxers ☐Osteoporosis meds (bisphosphonates) ☐Pain killers ☐Nerve pills ☐Stimulants ☐Tranquilizers
*****PLEASE LIST *ALL* MEDICATIONS:**_____

Do you have any of the following medical conditions, diseases or procedures?

☐Alcohol/drug abuse	☐Epilepsy/seizures	☐Leukemia
☐Anemia	☐Frequent/severe headaches	☐Liver problems
☐Arthritis/Rheumatism	☐Fainting	☐Mitral valve prolapse
☐Artificial joints/bones	☐Glaucoma	☐Nervousness/anxiety
☐Artificial valves	☐Heart attack	☐Pacemaker
☐Asthma	☐Heart burn/acid reflux	☐Psychiatric problems
☐Back/neck problems	☐Heart disease	☐Rheumatic fever
☐Cancer/tumors	☐Heart murmur	☐Scarlet fever
☐Chemo/radiation therapy	☐Heart surgery	☐Shingles
☐Chest pains/angina	☐Hepatitis A/B/C/D	☐Sinus problems
☐Congenital heart defect	☐High/low blood pressure	☐Stomach problems/ulcers
☐Cosmetic surgery	☐High cholesterol	☐Stroke
☐Diabetes/hypoglycemia	☐HIV/AIDS/ARC	☐Thyroid problems
☐Difficulty breathing	☐Jaw/TMJ problems	☐Tuberculosis
☐Emphysema/respiratory problems	☐Kidney problems	☐Venereal disease

*****Do you require pre-medication before dental procedures? ☐ Yes ☐ No ☐ I don't know**
Please list any other surgeries or medical conditions you have had in the past or currently have now:

_____

Are you allergic to any of the following: ☐Aspirin ☐Dental anesthetics ☐Latex ☐Penicillin/amoxicillin ☐Sulfas ☐Tetracycline ☐Dental anesthetic ☐Foods:_____ ☐Other:_____
Do you use tobacco products? ☐No ☐Yes What type?_____ How much?_____ How long?_____
Please rate your general health from 1-10 (10 being the best) ____
Have you ever taken the drug Phen-fen and/or Redux?☐Yes ☐No Do you wear contact lenses?☐Yes ☐No
For women: Are you taking birth control? ☐Yes ☐No How many children have you had?____
Are you or could you be pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No

- *We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.*
- *I authorize the staff to perform and necessary services needed during diagnosis and treatment.*
- *I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.*

Patient/Guardian signature: _____ Date:_____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize this office to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of this office's Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that this office reserves the right to change the terms of this notice from time to time and that I may contact this office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information in used and disclosed to carry out treatment, payment and healthcare operations, but that this office is not required to agree to these requested restrictions. However, if this office does agree, it is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20___.

Printed patient name: _____

Relationship to patient: _____

Signature: _____

Practice name:
Lindsey Clark-Fass, DDS, PC
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