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PATIENT INFO & MEDICAL HISTORY

Please fill out all the following information accurately for us to better care for you. All Information is strictly confidential

Reason for today's dental visit: ______________________________

If you are a new patient, how or from whom did you hear about us? ______________________________

- If family members are patients at our practice, list name(s): ______________________________

PATIENT INFO

Patient's Name: ______________________________ Sex: ☐ M ☐ F
Last First MI Nickname

DOB: ______/______/_______ Email: ______________________ Status: ☐ Child ☐ Single ☐ Married

Address: ______________________ City: ______________ State: ______ Zip Code: __________

Home #: ______________ Cell #: ______________ Work #: ______________

Emergency Contact: ______________________ Relation: ______________ Phone #:______________

RESPONSIBLE PARTY'S INFO: *if different from patient (Spouse, Parent/Guardian, Caretaker, etc)*

Responsible Party's Name: ______________________________ Sex: ☐ M ☐ F
Last First MI

DOB: ______/______/_______ Relation to patient: ______________ Email: ______________________

Home #: ______________ Cell #: ______________ Work #: ______________

Insurance Co.*______________________ ID or SSN #: ______________ Group #: ______________

Employer: ______________________ *Please let us know if you have a secondary insurance

Patient Medical History:

Check any of the following medical conditions which you had or have: ☐ No Medical Conditions

☐ Acid Reflux
☐ ADD/ADHD
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Autistic Spectrum Disorder
☐ Blood Disorder
☐ Bone Disease
☐ Cancer
☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ Drug Addiction/Alcoholism
☐ Emphysema
☐ Epilepsy/Seizure
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV+ / AIDS
☐ Implants/artificial joints
☐ Kidney Disorder
☐ Liver Disease
☐ Pregnancy
☐ Prolonged bleeding
☐ Psychiatric Treatment
☐ Rheumatic Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Issues
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease

☐ Other Conditions or Details: ______________________________
____

☐ Past Surgeries: ______________________________

Check any of the following medications you are allergic to: ☐ No Drug Allergies

☐ Acetaminophen / Tylenol
☐ Barbiturates / sedatives
☐ Codeine
☐ Latex
☐ Local Anesthetic
☐ NSAIDs: Aspirin, Ibuprofen, Aleve
☐ Penicillin / Amoxicillin
☐ Sulfa Drugs
☐ Other Antibiotics
☐ Other Narcotics

☐ Other Allergies or Details: ______________________________

Medications: ☐ None ☐ Yes, I am taking the following: ______________________________
____

☐ Yes, I currently or have taken Bisphosphonates in either pill or IV form for bone issues. (ie. Fosamax, Zoledronate, Boniva, etc.)

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if any medications change, I will inform my dentist at my next appointment.

______________________________ ______________________________

Signature of Patient/Parent/Guardian Date Signature of Dentist Date

DENTAL HISTORY FORM

Please check any of the following that apply to you.

- ☐ I have issues with dry mouth
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort with chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Jaw Joint Pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Name of Previous Dentist:

____

City/State: ___________________________

Phone Number: _______________________

Please share the following dates:

Your last cleaning: ___ /___

Your last complete X-Rays ___ /___

Why did you leave your previous dentist?

____

What is the most important thing to you about your dental visit today?

____

What is the most important thing to you about your future smile and dental health?

____

____

On a scale of 1 -10, with 10 the highest rating:

How would you rate your smile?

1 2 3 4 5 6 7 8 9 10

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

If you could change your smile, you would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Show less gums when I smile
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Make my teeth smaller or larger
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Mark any statement below that may apply:

- ☐ Because I am not confident in my teeth, I sometimes hesitate to smile.
- ☐ Concerns over what the end result might look like has been a factor in me not having aesthetic dentistry in my mouth.
- ☐ I would like to know about different methods to improve my oral health.

Please let us know of any additional comments, concerns, or requests you may have below ☻

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

- **TREATMENT**
  We may disclose your health information to other health care professionals within our practice or practices we refer you to as a patient. For the purpose of treatment, payment or any other way we see necessary to the benefit of the patient's care.

- **PAYMENT**
  We may disclose your health information to your insurance provider for the sole purpose of collecting payment for procedures rendered.

- **WORKERS COMPENSATION**
  We may disclose your health information as necessary to comply with State Workers Compensation Laws.

- **EMERGENCIES**
  We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

- **PUBLIC HEALTH**
  As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

INFORMED CONSENT FOR NEW PATIENTS DIAGNOSTIC CARE & PRIVACY PRACTICE ACKNOWLEDGEMENT

PATIENT NAME: ____ **DOB:**______________________

EXAM and CLEANING **Initial**______________

Regular exams and cleanings play an important role in proper dental health. They allow the dentist to screen for dental caries, gingival and/or periodontal issues or orthodontic needs. An exam, radiographs, cleaning, and fluoride treatment are usually performed. Risks include but are not limited to: sensitivity or bleeding of the teeth or gums due to scaling. I understand that if I choose not to maintain regular check-ups and/or cleanings, this decision may result in decay, pain, infection, and/or orthodontic or periodontal problems. Therefore, I elect to have a dental exam, x-rays, and if time permits, cleaning and fluoride as described above.

RADIOGRAPHS (X-RAYS) **Initial**______________

X-rays are used as an important diagnostic tool for the dentist. How often x-rays are taken depends on the age, risk for disease, and signs and symptoms of the patient. Our office follows the recommended guidelines from the FDA, American Academy of Pediatric Dentistry, and American Dental Association. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth visually. An x-ray may reveal the presence of small cavities between the teeth before they become more painful and more expensive to treat. X-rays also reveal infections in the bone, abscesses, cysts, developmental abnormalities and some types of tumors. Risks from radiation exposure have been significantly reduced by improvements in digital technology utilized in this office. Risks of NOT taking x-rays include but are not limited to: a failure to diagnose and treat conditions before signs and symptoms have developed that can threaten oral and general health. The benefits of dental x-rays to promote adequate and quick diagnosis outweigh the potential adverse effects. Therefore, I elect to proceed with dental x-rays.

HIPAA **Initial**______________

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 you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. 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 your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you 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 is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are 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.

I understand that dentistry is not an exact science; 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 authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient or Parent/Guardian Signature____________________________________ **Date** ______________

Parent/Guardian Name (if applicable)_____________________________________