MEDICAL Arts DENTAL

Welcome!

We are delighted to welcome you to Medical Arts Dental, and are pleased you have chosen us to serve your dental needs! Our gentle and caring dental team is serious about providing a wide range of dental services with meticulous attention to detail, and we are proud of our dedication to our patients.

If for some reason you **cannot keep this appointment please contact our clinic** so we can reschedule the appointment. At your first appointment we will do a thorough and careful examination for you, this appointment will take approximately 2 **hours**. We would also like to visit with you about ***your*** desires for your dental health. Our goal is to help you feel and look you're very best. So we may treat you safely, please complete the following medical and dental health forms and registration materials and bring them with you, along with your insurance cards (if any).

Thanks again for choosing our dental practice! If you have any questions please feel free to contact us at 320-253-9270.

WELCOME!

PATIENT REGISTRATION INFORMATION

LAST NAME_____ FIRST_____ MI_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL_____ EMAIL_____

PATIENT BIRTH DATE_____ AGE_____ ☐ FEMALE ☐ MALE

PATIENT SSN_____

How did you hear about us?

☐ Yellowbook ☐ Dex-Yellow-Pages ☐ **Website** ☐ **Billboard** ☐ **Radio** ☐ Promo-Pak
☐ Care to Share ☐ BNI (name)_____ ☐ **Friend (name)_____**

How would you like us to confirm your appointments?

☐ Phone - home, work or cell (please circle) ☐ Text message via cell phone ☐ Email

PATIENT'S EMPLOYER_____

WORK ADDRESS_____

WORK PHONE_____

EMERGENCY CONTACT_____ PHONE_____

RELATIONSHIP TO PATIENT_____

PARENTS' NAMES (if above is a minor) _____

If parent/guardian is not present at child's appointment, number he/she can be reached at immediately (if needed during appointment) _____

SSN MOTHER_____ SSN FATHER_____

PARENT'S EMPLOYER_____

WORK ADDRESS_____

WORK PHONE_____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

INSURANCE CO. PHONE_____ GROUP #_____

SUBSCRIBER NAME_____BIRTHDATE_____

RELATIONSHIP TO PATIENT_____

SUBSCRIBER ID# OR SSN_____

COVERAGE: SELF_____ SPOUSE_____ FAMILY_____

(Please complete other side)

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids necessary to make a thorough diagnosis and treatment plan.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon. I further authorize the doctor to perform such procedures as are necessary, in the exercise of his/her professional judgment to remedy any unforeseen condition which may be revealed during the course of the original treatment.
3. I agree to the use of anesthetics, analgesics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that an 18% APR may be added to my account. If required, I also understand a check of my credit history may be made.
5. I understand that it is my responsibility to come to my scheduled appointments; if I am unable to make a scheduled appointment, I must call at least 24 hours in advance. If I skip an appointment, or do not call 24 hours in advance, a ***$50 failure fee*** will be assessed to my account.

Patient (*or Legal Guardian) Signature_____ Date_____

*Relationship to patient_____

Medical Arts Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. . We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation.. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

* Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

MEDICAL Arts DENTAL

NAME:	DOB:

Medical and Dental Information Questionnaire

Reason for your visit today:

_____

_____

Date of last dental visit: _____

Date of last dental cleaning:_____

Date of last full mouth x-rays:_____

MEDICAL INFORMATION

Yes No

☐ ☐ Has there been any change in your general health within the past year? If so, please describe:

_____

_____

_____

☐ ☐ Are you now under the care of a physician? Please include the name and phone number for your physician.

_____

_____

_____

☐ ☐ Have you been hospitalized for any surgical operation or serious illness? If so, please describe:

_____

_____

_____

Do you ***have*** or have you ***had*** any of the following conditions?

Yes No

☐ ☐ Rheumatic fever/ rheumatic heart disease
☐ ☐ Heart murmur
☐ ☐ Infective endocarditis
☐ ☐ Congenital heart defect
☐ ☐ Mitral valve prolapse
☐ ☐ Heart Disease
☐ ☐ Heart Attack
☐ ☐ Chest pain
☐ ☐ Heart Surgery
☐ ☐ Artificial heart valve or Pacemaker
☐ ☐ High blood pressure

Yes No

☐ ☐ Congestive heart failure
☐ ☐ Stroke
☐ ☐ Vascular disease
☐ ☐ Arthritis, Rheumatism
☐ ☐ Artificial Joints
☐ ☐ Prosthetic devices or implants
☐ ☐ Liver disease
☐ ☐ Hepatitis A B C (circle)
☐ ☐ Kidney trouble
☐ ☐ Diabetes, type I or II (circle)
☐ ☐ Thyroid problems
☐ ☐ Allergies, hay fever, hives
☐ ☐ Sinus trouble
☐ ☐ Asthma
☐ ☐ COPD
☐ ☐ Emphysema
☐ ☐ Tuberculosis
☐ ☐ Anemia
☐ ☐ Leukemia
☐ ☐ Tumors
☐ ☐ Chemotherapy
☐ ☐ Radiation therapy
☐ ☐ Ulcers
☐ ☐ Acid reflux
☐ ☐ Eating Disorder
☐ ☐ Bleeding disorder
☐ ☐ HIV or AIDS
☐ ☐ Venereal disease
☐ ☐ Glaucoma
☐ ☐ Alcohol/chemical dependency
☐ ☐ Psychiatric/Psychological care
☐ ☐ Anxiety and/or Depression

Yes No

☐ ☐ Latex sensitivity
☐ ☐ Epilepsy or Seizures
☐ ☐ Cold sores/fever blisters
☐ ☐ Do you use **tobacco**?
What kind? _____
How much? _____
How Long? _____

Do you have or have you had:

☐ ☐ Dry mouth much of the time?
☐ ☐ Sores in the mouth?
☐ ☐ White lesions in the mouth?
☐ ☐ Lumps or tumors in the mouth or neck?
☐ ☐ Blood transfusion?
☐ ☐ Unusual weight loss?
☐ ☐ Have you ever taken bone loss prevention drugs such as Fosamax, Actonel or Boniva?
☐ ☐ Do you have any ***disease***, ***condition*** or ***problem*** not listed we should know about? Please describe:

_____

_____

_____

_____

_____

☐ ☐ Are you aware of having an ***allergic*** (or ***adverse***) reaction to any substance or medication? Please list:

_____

_____

_____

_____

_____

Medications being taken now—Please list all drugs, vitamins, pills and/or herbal remedies, including regular dosages of aspirin:

_____
_____
_____
_____
_____
_____

Women:

Yes No

□ □ Are you taking contraceptives (birth control prescriptions)?

□ □ Are you pregnant or is it possible that you are pregnant?

If yes, how many months pregnant? _____

□ □ Have you had a low birth weight baby?

□ □ Are you presently nursing?

DENTAL INFORMATION

Yes No

□ □ Have you ever been told to take a pre-medication (antibiotics) prior to dental treatment? If so, what do you take?

_____

□ □ Have you ever had an upsetting dental experience? If yes, please describe:

_____

_____

□ □ Is it important for you to keep your teeth?

□ □ Are you dissatisfied with the appearance of your teeth?

□ □ Are you dissatisfied with the function of your teeth?

□ □ Does food tend to become caught between your teeth?

□ □ Do your gums often bleed while brushing?

Yes No

□ □ Have you noticed any loosening of teeth?

□ □ Have you had an injury to your head, neck or jaw?

Habits – Do you:

□ □ Clench your teeth while awake or asleep?

□ □ Bite your lips, cheek or tongue?

Jaw Problems - have you noticed:

□ □ Jaw noises (clicking or popping)?

□ □ Jaw pain (joint, ear, side of face)?

□ □ Difficulty opening or closing?

□ □ Difficulty chewing?

Have you had/ever:

□ □ Orthodontic treatment (braces)?

□ □ Gum treatment?

□ □ Your bite adjusted?

□ □ Worn a guard or other appliance?

This space is to be used for further explanation of conditions or for questions you may have:

_____
_____
_____
_____
_____
_____

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature – Patient (or parent/guardian if patient is under age 18) **Date**

History Review:

Dentist Signature:_____ **Date:**_____

MEDICAL Arts DENTAL

Dr. Julie Ann Nyland
Dr. Jennifer Lynn Dechaine

165 19th Street South
Suite 101
Sartell, MN 56377

320-253-9270
fax 320-255-5413
You may email radiographs to: jen@medicalartsdental.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Soc. Sec. #:_____

Address: _____

City, State, Zip: _____

DOB: _____

THIS WILL AUTHORIZE MEDICAL ARTS DENTAL TO REQUEST XRAYS AND RECORDS FROM:

_____

(Clinic name and/or Doctor's name)

The following information is to be released:

____ CURRENT RADIOGRAPHS

____ DENTAL RECORD

For the following Patients:

Name: _____ DOB:_____

Name: _____ DOB:_____

Name: _____ DOB:_____

Name: _____ DOB:_____

I am requesting this information be released for the following purpose:

____ Continued care by another provider ____Other

_____ _____

Patient/Parent signature Date

*Photocopies of the authorization may be accepted in leiu of the original.