

Date _____

THANK YOU FOR SELECTING OUR DENTAL TEAM

PATIENT NAME & PREFERRED NAME		SOCIAL SECURITY NUMBER	BIRTH DATE	
_____		_____	/ /	
HOME ADDRESS		City, State, Zip Code	Male	Female
_____		_____	<input type="checkbox"/>	<input type="checkbox"/>
Home Phone	Cell Phone	E-Mail	Marital Status	Single Married
() _____	() _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Occupation: _____			Would it be OK to contact you by E-Mail or Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental Insurance		
Name of Insured	Social Security Number	Birth Date
_____	_____	/ /
Dental insurance plan name: _____		
Subscriber ID # _____		Group #: _____
Dental Insurance address _____		
City: _____		State: _____ Zip: _____
Dental Insurance Provider Phone Number _____		

How did you hear about our office?

Who selected this Office? Self Spouse Parent Employer

Where did you find the phone number this Office?

Yellow Pages Insurance Plan Direct mailing Other Internet

If a family member or friend referred you, whom may we thank for referring you.

CONSENT

● I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ **Date** _____ **Relationship to the Patient** _____

TERMS AND CONDITONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any service performed without prior financial arrangement, must be paid for at the time of services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimated listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

There may be a charge for any missed or appointments not cancelled 48 hours before the appointment time.

PATIENT DENTAL HISTORY

Why have you come to see us today?(e.g.; pain, checkup, etc) _____

Previous Dentist _____ Last Visit _____

Rate your smile on a scale from 1–10 (10 being the best): _____

If you could change something about your smile or teeth, what would that be?

Are you nervous about seeing the dentist? Yes! No If yes, why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(Please circle each)

Y N I clench or grind my teeth the day or while sleeping. Y N My gums feel tender or swollen.

Y N My gums bleed while brushing or flossing. Y N I avoid brushing part of mouth due to pain.

What are your dental goals? _____
(e.g.: appearance, dental health, financial, etc?)

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? please circle Y for yes or N for No.

1. Y N Heart Disease	20. Y N I smoke or use tobacco. If yes, how much per day? _____
2. Y N Heart Murmur/Mitral Valve Prolapse	21. Y N I usually take antibiotics prior to dental treatment.
3. Y N Stroke	22. Y N Liver Disease
4. Y N Congenital Heart Lesions	23. Y N Hepatitis Type _____
5. Y N Rheumatic Fever	24. Y N Diabetes
6. Y N Abnormal Blood Pressure	25. Y N Arthritis
7. Y N Anemia	26. Y N Kidney Disease
8. Y N Prolonged Bleeding Disorder	27. Y N AIDS
9. Y N Tuberculosis or Lung Disease	28. Y N Fainting Spells
10. Y N Asthma	28. Y N History of Emotional or Nervous Disorders
11. Y N Sinus Trouble	
12. Y N Epilepsy/Seizures	
13. Y N Cancer/Chemotherapy	WOMEN
14. Y N Tumor or Malignancy	29. Y N Are you nursing or pregnant?
15. Y N Radiation	
17. Y N Implant/Artificial Joints <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other	
18. Y N I have had major surgery: Year _____ Type of operation: _____	
19. Y N Do you have any other medical problem or medical history not listed on this form?	

<p>Are you allergic to any of the following? Please circle Y for Yes or N for No</p> <p>30. Y N Aspirin 31. Y N Ibuprofen 32. Y N Sulfa Drugs/Sulfites/Sulfides 33. Y N Penicillin 34. Y N Codeine 35. Y N Latex, Metals, Plastics 36. Y N Local Anesthetics 37. Y N Other Medications – Which Ones? _____</p> <p>_____</p>	<p>Please list all medications you are currently taking:</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's name: _____</p> <p>Phone Number: _____</p>
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In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Photo and Digital Image Consent

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Consent for Use and Disclosures of Personal Health Information

I authorize Dr. Bunchman and his dental team to use and disclose my Protected Health Information (PHI) for the purpose of healthcare operations, treatment and payment activities. I have read the Notice of Privacy Policies to gain clear understanding of how you use and disclose of my PHI. I understand I may contact Dr. Bunchman's office at any time to request a copy of the Notice of Privacy Policies at no charge.

I understand that when I sign this form, I am acknowledging that I have read, understood all pages above including my personal information, medical/dental information, office policies, consent for Use and Disclosure of personal Health Information, and Consent for Services.

Signed _____ Date _____