Date ____________

PATIENT ______________________________ AGE ________ BIRTHDATE ____________

ADDRESS ______________________________ HOME PHONE ____________

CITY ____________ ST ______ ZIP ________ CELL PHONE ____________

EMPLOYER ______________________________

EMPLOYER'S ADDRESS ______________________________ BUS. PHONE ____________

S.S.# ______________________________ D.L.# ____________

SPOUSE ______________________________

SPOUSE'S EMPLOYER ______________________________

ADDRESS BUS. PHONE ______________________________ BUS. PHONE ____________

COMPLETE ONLY IF PATIENT IS A MINOR

FATHER/ MOTHER ______________________________ **S.S.#** ____________

EMPLOYER ______________________________ **D.L.#** ____________

ADDRESS ______________________________ **BUS. PHONE** ____________

WHOM MAY WE THANK FOR REFERRING? ______________________________

I GIVE PERMISSION TO THE DOCTORS AT TRAIL CREEK DENTAL AND/OR THEIR DESIGNATED STAFF TO PERFORM PROCEDURES, INCLUDING BUT NOT LIMITED TO: GIVING ANESTHETICS AND MEDICATIONS; MAKING RADIOGRAPHS AND PHOTOGRAPHS; REMOVING AND/OR RESTORING TEETH, AND ANY OTHER PROCEDURES NECESSARY FOR MY DENTAL HEALTH.

SIGNATURE ______________________________ DATE ____________

GUARDIAN SIGNATURE (IF MINOR) ______________________________

PHYSICIAN ______________________________ PHYSICIAN'S TEL. NO. ____________

LAST TIME AT PHYSICIAN ____________ FOR WHAT PURPOSE? ____________

IN CASE OF EMERGENCY PLEASE CALL: 1. ______________________________ TEL NO. ____________

2. ______________________________ TEL NO. ____________

PATIENT INFORMATION

DENTAL HISTORY

Patient Name________________________ Date ____________

Reason for visit: ________________________

When was you last dental visit? ____________

How often do you brush your teeth?____________

Hard or soft brush? ____________ Other?____________

Do you use dental floss? ____________ How often?____________

Do your gums ever bleed or hurt when brushing or flossing? yes ☐ no ☐

Have you ever been instructed in home care procedures in a dental office? yes ☐ no ☐

Are you familiar with the term "preventative dentistry" yes ☐ no ☐

Do you feel twinges or pain when your teeth come into contact with cold, sweet, hot, biting pressure? yes ☐ no ☐

Which one? ________________________

Have you lost any permanent teeth? yes ☐ no ☐

Were they replaced? yes ☐ no ☐

Do your parents or anyone in your family wear dentures? yes ☐ no ☐

Who? ________________________

Do you have headaches? yes ☐ no ☐

How often? ________________________

Do you "grind or clinch" your teeth while sleeping? ____ during the day? ____

Do you ever have pain or "popping" of you jaw?

Which side?________________________

Do you often have pain or spasms in neck or shoulders? yes ☐ no ☐

Do you chew more on one side of your mouth than the other? yes ☐ no ☐

If so, explain ________________________

Do you feel your teeth are in good, fair or poor condition?

____

MEDICAL HISTORY

Are you taking any medication now? Yes ☐ No ☐

Have you been hospitalized in the last 2 years? yes ☐ no ☐

What medications are you taking? ________________________

For what purpose? ________________________

Have you had:

Heart Disease	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Rheumatic fever	Yes ☐ No ☐	Congenital heart lesions	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐
Abnormal blood pressure	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Ulcers	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
Tuberculosis or lung disease	Yes ☐ No ☐	Asthma or hay fever	Yes ☐ No ☐	Women:	
Diabetes	Yes ☐ No ☐	Sinus trouble	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐

Are you taking any medications now: Prescription, Over the Counter; and or Illicit drugs (HERBAL, DIET, MARIJUANA, COCAINE, METHAMPHETAMINE, SPEED, CRACK, EPHEDRINE, ECT...)? Yes ☐ No ☐ ________________________

Have you ever been treated for venereal diseases - syphilis, gonorrhea, herpes? yes ☐ no ☐ When? ____________

Have you had any blood testing in the last 2 years? yes ☐ no ☐

When?________________________

Have you had any blood transfusions in the last 2 years? yes ☐ no ☐

When? ________________________

Any abnormalities? ____________ What? ____________

Do you have any reason to believe you have been exposed to the HIV virus? yes ☐ no ☐ yes ☐ no ☐

Have you ever been tested positive for HIV infections? yes ☐ no ☐

Are you HIV positive?

Have you been treated for alcohol or drug dependency? yes ☐ no ☐

When? ________________________

Is there anything else the Doctor should know before beginning treatment? ________________________

Are you allergic to: Latex ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ ____________

PATIENT HISTORY

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND AMERICAN EXPRESS. FINANCIAL ARRANGEMENTS ARE AVAILABLE THROUGH WELLS FARGO BANK. (For Details See Front Desk)

REGARDING INSURANCE:

As a courtesy to you we may accept assignment on insurance benefits on your first visit, only if you have your insurance card and a complete claim form with you. (If you do not have this information with you the balance must be paid in full. We will give you printed itemized statement of services rendered). However we do require 35% of the bill to be paid at time of service. The balance is your responsibility. If we have not received payment from the insurance company within 45 days, you will be required to pay the balance and we will reimburse you when insurance pays. This is a courtesy to you from us. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **Please be aware that some and perhaps all of the services provided may be non-covered services and considered reasonable and necessary under your insurance plan. Please read your policy carefully. We do not adjust our fees according to insurance payment.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to a visa/mastercard, or payment by cash or check at time of service has been verified.

Thank you for understanding our Financial Policy. I have read and understand this Financial Policy.

____________________________ Signature of Patient or Responsible Party

____________________________ Date

Trail Creek Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have read and received a copy of this office's Notice of Privacy Practices.

(Please Print)

____

(Signature)

____

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

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