

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date: _____ Patients Name _____
Last First Middle
 Address _____
Street City State Zip
 Home Phone (____) _____ Social Security # _____ - _____ - _____ Drivers License # _____
 Birthdate ____ / ____ / ____ If patient is a minor, give parent's/guardian's name _____
 If patient is a full-time student, fill in school name _____
 Name of nearest relative not living with you _____ Relationship _____
 Complete Address _____ Phone (____) _____
 Emergency Contact _____ Phone (____) _____

Responsible Party Information

Name _____
Last First Middle Marital Status
 Residence _____
Street City State Zip
 Mailing Address _____
Street City State Zip
 How long at this address _____ Home Phone (____) _____ Work Phone (____) _____
 Previous address (if less than 3 years) _____
Street City State Zip
 Social Security # _____ Birthdate _____ Relationship to Patient _____
 Employer _____ Occupation _____ No. Years Employed _____
 Employer Address _____
 Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
 Insurance Company _____ Group No. _____
 Insurance Co. Address _____ Ph # _____
 Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____
 Do you have dual coverage? Yes _____ No _____ If yes: Please complete the following secondary insurance information.
 Insured's Name _____ Insured's Soc. Sec. # _____
 Insurance Co. _____ Group No. _____ Local No. _____
 Insurance Co. Address _____ Ph # _____
 Insured's Employer _____ Ph # _____

Oral Information

Do your gums bleed when you brush? Yes _____ No _____
 Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____
 Do you grind or clench your teeth? Yes _____ No _____
 Do you have any fear of dental work? Yes _____ No _____
 Date of last dental examination _____ What was done at that time? _____

 How would you describe your current dental problem? _____

 How do you feel about the appearance of your teeth? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____	
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICATIONS

List medications you are currently taking:

Have you ever taken Fen-Phen? Yes No

Have you ever taken Redux? Yes No

When were your last dental xrays? _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

DATE

PATIENT'S/PARENT'S SIGNATURE

P/BP

DOCTOR'S SIGNATURE

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

Has there been any changes in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

DENTAL TREATMENT CONSENT FORM

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Exam + X-Rays _____
(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials _____)

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
(Initials _____)

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
(Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials _____)

I understand that dentistry is not an exact science and that, 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 ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

Office Policy

Dear Patients:

Welcome to our office. We will do our best to make your visit as comfortable as possible. We are pleased that you have chosen our office for your dental health care needs. We strive to provide our patients with high quality comprehensive dental care at a reasonable fee.

On your first visit expect:

A thorough examination and review of your oral health including necessary x-rays. Cleanings are not done on the first visit.

Your recommended treatment will be explained and you will receive an estimate of your cost according to your particular insurance plan. Treatment rendered and not paid by your insurance company, will be your responsibility to pay.

After this initial appointment, you may schedule a return appointment to begin your dental treatment. Charges are due and expected on the date of service. For your convenience, we offer a credit service. Ask for information at the front desk.

As a courtesy to our patients, we will confirm your appointment prior to the day of your appointment, and the same courtesy is expected from you, should there be a need to change or cancel your appointment. We ask that you contact our office within (48) hours to avoid a charge of \$25.00 for broken appointments.

X-rays will be released upon signed authorization and a \$20.00 duplication fee (per member) will be charged. We are required by law to have a copy of x-rays in the chart.

I have read and understand the above policy.

Signature _____

Date _____

PATIENT CONSENT FORM

- Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your Protected Health Information (PHI);

You have the right to review our *Notice of Privacy Practices* before signing this *Patient Consent Form*. Please take the time to do so now. A copy is attached.

You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. *Request for Restriction of PHI* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;

- Our office does not have to agree with your *Request for Restriction of PHI*. If we agree to your *Request for Restriction of PHI*, we shall honor that agreement.

You have the right to revoke this *Patient Consent Form*. *Revocation of Consent* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;

- A *Revocation of Consent*, does not affect disclosures made prior to the date the *Revocation* was made.
- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" *Notice* on the first visit after changes to the *Notice* were made.
- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing/Payment, and Dental Office Operations as outlined in our *Notice*.
- Our office may condition dental treatment upon execution of this *Patient Consent Form*.
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Patient Consent was signed by: _____
(Print Name of Patient or Representative) (Relationship to Patient)

Patient's Signature

_____/_____/_____
Date

Witnessed by: _____
(Print Name of Privacy Officer or Office Contact Person)

(Title)

Signature

_____/_____/_____
Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You have the right to refuse to sign this Acknowledgement

I, _____, have
(Signature of Patient)

received a copy of this office's NOTICE OF PRIVACY PRACTICES
as required by federal law.

Print Patient's Name

Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgment of receipt of our NOTICE OF PRIVACY PRACTICES. We were unable to obtain acknowledgement for the following reason:

Patient refused to sign

Other _____
(Possible reasons: Language difficulty, communication barriers, dental emergency)

(Printed Name)

(Signature of employee attempting to gain acknowledgement)

For office communication purposes we kindly request that you fill out the information requested below. Your information will be confidential and will be only used for confirmation and communication purposes between our office and you.

Cell Phone Number: _____

Email Address: _____