Acquaintance Form and Dental History

Today's Date: _____

About You:

Name (Last, First, Mi)_____

Mr. Mrs. Ms. Dr. I prefer to be called:_____ Male Female

Birth date: (___/___/_____) Age:_____ Marital Status:_____ SSN#:_____

Home Address:_____ E-mail address:_____

_____

Home Phone:( )___-_____Cell Phone: ( )___-____ Work Phone: ( )___-_____x___

Employer:_____

Employer Address:_____

Occupation:_____ How long there?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

Spouse Information:

His/Her Name:_____ Birth date:(MM/DD/YYYY)_____

Employer:_____

Work #( )____-_____x____ Cell# ( )___-____x____

Person Responsible for Account: Self Spouse

Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the office of Frank J Fruce DMD of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature:_____Date:_____

Dental Insurance:

Primary Insurance

Insured's Name:_____ Relationship:_____ Insured's Birth date:_____

Insured's ID#:_____ Insured's Employer:_____

Insurance Company Name:_____ Insurance Company Address:_____

_____

Insurance Company Phone #:( )_____-_____ Group #_____

Secondary Insurance

Insured's Name:_____ Relationship:_____ Insured's Birth date:_____

Insured's ID#:_____ Insured's Employer:_____

Insurance Company Name:_____ Insurance Company Address:_____

_____

Insurance Company Phone #:( )_____-_____ Group #_____

Neighbor or Relative not living with you:

Name:_____ Relation:_____

Phone #:( )___-_____

Address:_____

Medical History:

Primary care physician:_____ Phone#:( )___-____ Date of last visit:_____

Your current physical health is: Good Fair Poor Do you smoke or use tobacco? _____

Are you taking any prescription/OTC or herbal supplemental drugs?_____

For Women: Are you using a prescribed method of birth control?_____

Are you pregnant?_____ (if yes)Week#_____ Are you nursing?_____

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding Alcohol/Drug Abuse Anemia Arthritis

Artificial Bones/Joints/Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis

Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy

Fainting Spells Glaucoma Hay Fever Heart Attack HBP Heart Murmur Heart Surgery

Hemophilia Hepatitis Herpes/Fever Blisters HIV+/AIDS Hospitalized for Any Reason

Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse

Osteoporosis Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/Scarlet Fever

Seizures Shingles Sickle Cell Disease Sinuses Stroke Thyroid Problems

Tuberculosis(TB) Ulcer Venereal Disease

Other:_____

Are you allergic to any of the following?

Aspirin Codeine Dental Anesthetics Erythromycin Latex Penicillin

Tetracycline Other:_____

Dental Health:

Previous Dentist:_____ Last dental Visit?_____ Reason?_____

What is your immediate dental concern? _____

On a scale of 1 to 10, how would you rate your mouth (10 is best)? ____On a scale of 1 to 10, how would you like it to be? ___ Have you ever had a bad reaction to a dental anesthetic?_____

Is your oral health goal to keep your natural teeth for a lifetime? _____ Do you feel it is possible to do that? ___

Please help us understand your daily oral hygiene care by circling the items you use:

Manual Tooth Brush	Electric Tooth Brush	Floss	Floss Threader	Proxibrush
Waterpik	Rubber Tip	Stimudents	Fluoride gel	Mouth Wash
Tongue Scraper	Other _____			

How often do you brush your teeth? _____ Floss? _____

Do you avoid brushing any part of your mouth? _____

Do you have fluoridated water supply? _____

Have you ever been told by your previous dentist that you have periodontal disease? _____

Do you have any areas in your mouth that are sensitive to cold liquids? _____

If so, where? Upper Right Lower Right Upper Left Lower Left.

Do you have difficulty swallowing? _____

Have you noticed any loose teeth or change in your bite? _____

Do you have any sores, lumps or irritations anywhere in your mouth? _____

Do you consume a high content of carbohydrates and or sugary foods (Do you drink soda on a regular basis)?_____

Have you noticed any soreness or tenderness on your gum tissue at times? _____

Do you ever notice some bleeding of your gum tissue at the time when you brush your teeth? _____

Do you get cold sores or mouth ulcers frequently? _____

Do you get frequent headaches? _____ Do you have difficulty opening your mouth widely? _____

Do your jaws feel tired after eating?_____After you wake up in the morning? _____

Do you ever hear popping or clicking sounds when you chew? _____

Do you ever have any pain in your head, neck, shoulders, and or back?_____

Have you had a night guard made for you? _____

Do you have dental implants? _____

Do you wear partials or dentures? _____ If so, how old are they? _____ Do they fit well? _____

Have you ever had prolonged bleeding following extractions in the past? _____

Have you ever worn braces to straighten your teeth? _____

Is there anything about the appearance and or function of your teeth you would like changed?

_____

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

Would you like to know about all of the different types of cosmetic options available to you in dentistry today?

_____

Do you suffer anxiety or gagging during dental procedures? _____

Please describe your past dental care and what you are looking for from us in your future dental care?

_____

Is there anything we can do to make your visits more comfortable, such as knees elevated, additional neck support, difficulty when placed in a reclined position? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

Dr. Frank J. Fruce, DMD

Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent

*Name:*_____

*Address:*_____*Telephone:*_____

*SS#:*_____

Section B: To the Patient

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 health information.

Notice of Privacy Practices: You will 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 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Office Manager
106 West First Street
Fulton, New York 13069
315-593-8366

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. 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.

Signature

*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.

Frank J Fruce, DMD
106 West First Street
Fulton, NY 13069
(315) 593-8366

Vital Information about your Dental Insurance

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. **In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be.** Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Help you maximize your dental benefits.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow for correct filing of claims.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance.

We thank you for choosing our office and we will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy in your chart and will give you one copy for your own records.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

Patient or Insured **Date**

Date: _____

Dear_____

Please transfer my written records and all xrays to:

Dr. Frank J. Fruce, D.M.D.
106 West First Street
Fulton, New York 13069
315-593-8366
315-593-8435 (fax)

Thank you.

_____
Name of patient

_____
Address

_____
Patient's signature

_____
Date of birth

CONSENT FORM

I _____ give permission to Dr. Frank J. Fruce to perform necessary dental treatment on myself and/or my dependent children (listed below). I give my permission to Dr. Fruce to perform any and all dental techniques and procedures, including but not limited to the administration of anesthetics. This treatment may include fillings, root canals, crowns, bridges, extractions, etc. I understand the risks involved with these procedures and give my consent to Dr. Fruce to perform these procedures as necessary, whether or not I am present at the actual appointment when the treatment for dependent children is rendered.

Signed _____

Date _____

Witness Signed _____

Date _____

Dependent Children:

_____

_____

_____