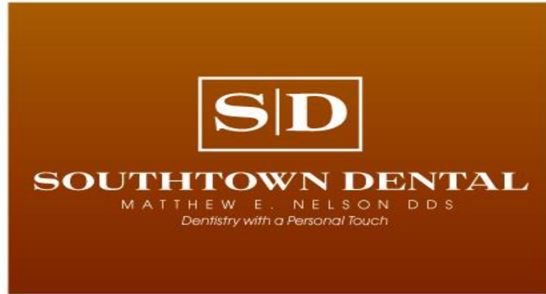

General Information

Patient Name____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Social Security Number_________________________________ Gender___________

Occupation_____________Employer__________________________Birthdate_________

Contact Information

Home Address____
STREET CITY ZIP

Business Address____
STREET CITY ZIP

Home Phone__________________ Business Phone______________________

Mobile Phone_________________ E-mail Address______________________

Preferences

What is your preferred method of contact?___________________________________

What is your ideal appointment time? (please circle one)
Early (6:30am- 10:30am) Mid-day (10:30am-2:30pm) Late (2:30pm- 6:30pm)

What is your ideal appointment day: (please circle one)
Tuesday Wednesday Thursday Friday

Health & Medical History

Accurate responses are essential to optimize your oral health. Now, more so than ever, systemic conditions have been connected to oral health. We want to do everything we can to customize our care and assist you and your medical doctors in optimizing your overall health.
All Responses are kept confidential.

General Health

1) Are you in good health? Y N

2) When was the last time you had a medical check up?___

____

3) Are you now under the care of a physician for a particular problem? Y N

*If so, what condition(s):____________________

____

4) Have you ever had any serious illnesses or hospitalizations? Y N

*If so, describe____________________________

____

5) Have you ever had any heart procedures? Y N

*If so, what procedure and when______________

____

6) Are you currently taking any medications? Y N

*If so, please list:___________________________

____

7) Have you ever taken a group of medications known as Fen-Phen or Redux? Y N

8) Have you ever taken medications or are scheduled to take either aledronate (Fosamax) or risendronate (Actonel) for Osteoporosis or Paget's Disease? Y N

9) Have you been taking or scheduled to be treated with intravenous bisphosphonates (Aredia or Zometa) for hypercalcemia, bone pain, or complications arising from multiple myeloma, or metastic cancer? Y N

10) Are you currently taking any vitamins or supplements? Y N

*If so, please list:___________________________

____

11) Are you allergic to or have you ever had an adverse reaction to any medication? Y N

*If so, please list___________________________

____

12) Do you use tobacco (smoking, chew, etc)? Y N

*If yes, how often?_________________________

13) Do you drink alcoholic beverages? Y N

*If yes, how often?_________________________

14) Do you use controlled substances (drug use)? Y N

***Questions 15 & 16 apply to females**

15) Are you pregnant or is there a chance you are pregnant? Y N

*If so, how many weeks?____________________

16) Are you currently nursing? Y N

Overview

Have you ever had any of the following? (check any that apply)

Condition		Condition	
Anemia		Heart Disease	
Arthritis		Heart Murmur	
Artificial Joints		High Blood Pressure	
Asthma		Implants	
Back Problems		Joint Replacement	
Bacterial Endocarditis		Kidney Disease	
Bleeding Disorders		Liver Disease	
Bronchitis		Low Blood Pressure	
Cancer		Nervous Disorders	
Cardiac Transplant		Osteoporosis	
Chemical Dependency		Pregnancy	
Circulatory Problems		Psychiatric Care	
Congenital Heart Lesion		Radiation Therapy	
Depression		Respiratory Problems	
Diabetes		Rheumatic Fever	
Dizziness		Sinus Problems	
Emphysema		Sleep Apnea	
Epilepsy		Special Diet	
Excessive Bleeding		Stroke	
Fainting Spells		Thyroid Disease	
Glaucoma		Tuberculosis	
Growths		Ulcers	
Head Injuries		Venereal Disease	

***If there anything else we should know about your health, please list**__________________________________

____

Dental & Oral Health History

General

1) When was your last dental visit?____
2) What is the most important thing to you about your dental visit today?
____
3) How often do you: Floss?__________________ Brush?____________________________
4) Are you aware of any current dental problems? Y N
*If yes, please explain____
5) Do you like the appearance of your teeth? Y N
*If no, please list what you don't like________________________________
____
6) Please answer the following on a scale of 1-10, with 10 being the highest rating:
How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10
How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10
*If not a 10, what would you change? ___________________________

Please mark any of the following conditions if you have them now or have had them in the past:

General Oral Health		**Teeth**		Thin enamel		**Gingiva (Gum) Tissue**	
Dry mouth		Fractures		Large fillings		Gingivitis	
Halitosis (bad breath)		Mobility		Sensitivity		Periodontal disease	
Oral cancer		Wear		Decay		Recession	

Treatment History

7) How would you rate your dental anxiety? None Low Medium High
8) Have you ever been sedated (valium, etc) for a dental procedure due to anxiety? Y N
9) Have you had any adverse reactions during dental treatment? Y N
*If yes, please explain____
10) Have you ever taken an antibiotic prior to your dental appointments? Y N
*If so, what for?____

Family History

11) Has anyone in your family had periodontal (gum) disease? Y N
12) Has anyone in your family had a denture? Y N

TMJ & Associated Structure History

14) Do you have any clicking, popping, or discomfort in your jaw? Y N
15) Do you grind or brux your teeth? Y N
16) Do you snore *OR* have trouble sleeping? Y N
17) Have you ever been told you have Sleep Apnea? Y N

If yes, please answer the following:

-Have you ever been given a CPAP device? Y N
-Are you comfortable with your CPAP and satisfied with its use? Y N

I understand the importance of a truthful and complete Health and Dental History to assist my dentist in providing the best care possible. I understand that it is my responsibility to inform the doctor of any changes to my health history.

____

Signature Date Dentist Initials

Insurance Assignment and Release

I certify that I or my dependent(s) am covered by ____

(name of insurance company)

and assign directly to Dr. __________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by my insurance company. I authorize the use of my signature on all insurance submissions. The above named doctor may use my minor/child's health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when treatment if terminated between the above named doctor and myself.

____ ____________________

Signature Date

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing an insurance claim does not relieve me from my responsibility for the payment of all charges. If I do not pay my bill within 30 days of the day service is rendered, a 1.5% monthly interest charge (18% yearly) will be assessed.

____ ____________________

Signature Date

Appointment Cancellation Policy

We expect at least 24 hours notice for cancellation of any appointments. We understand that emergencies do happen and some late cancellations are absolutely necessary. However, if a cancellation occurs less than 24 hours prior to an appointment, you will be subject to a $75 cancellation fee. By signing below, you understand that you are subject to a $75 fee for any late cancellations.

____ ____________________

Signature Date

Minor/ Child Consent

I am the parent, guardian, or legal representative of ____

(name of child or children)

I certify that there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to xrays, the administration of dental anesthetics, and any other treatment necessary by the dentist, whether or not I am present while the treatment is rendered.

____ ____________________

Signature of Parent, Guardian, or Personal Rep Date

Notice of Privacy Practices

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.
I, ________________________, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

____ ________________________________
Signature Date