WELCOME

Thank You for Selecting Our Dental Team.

To help us meet all your healthcare needs, please fill out this form completely (front and back) in ink.If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______________________________ Date______________

Soc. Sec. # ______________ Birthdate ______________ MALE ❑ FEMALE ❑

Home Phone ______________________ Cell Phone ______________

Address ______________ City__________ State ________ Zip ________

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School/College __________ City ________ State ____ ❑ Full-Time ❑ Part-Time

Patient's or Parent's Employer______________________ Work Phone______________

Business Address ______________ City__________ State________ Zip ________

Spouse or Parent's Name__________ Employer__________ Work Phone______________

Whom May We Thank for Referring You? ______________________________

Person to Contact in Case of Emergency ______________________ Phone______________

Responsible Party

Name of Person Responsible for this Account______________ Relationship to Patient______________

Address ______________________________ Home Phone ______________

Drivers License # ______________ Birthdate ________ Financial Institution______________

Employer ______________ Work Phone ______________ SS# ______________

Payment in full at each appointment. For your convenience, we offer the following methods of payments. Please check the option you prefer.

❑ Cash ❑ Personal Check ❑ Visa ❑ Mastercard ❑ Discover ❑ Care Credit

Dental Insurance Information

WE ARE NOT AN IN-NETWORK PROVIDER FOR ANY INSURANCE COMPANIES.

Name of Insured______________________________ Relationship to Patient______________

Birthdate ______________ Social Security #______________________________

Name of Employer ______________________________ Work Phone ______________

Insurance Company______________________________ Group # ______________

Health History Review: (FOR OFFICE USE ONLY)

Signature ______________ ______________ Date______________

Signature ______________ ______________ Date______________

Signature ______________ ______________ Date______________

Signature ______________ ______________ Date______________

Signature ______________ ______________ Date______________

Signature ______________ ______________ Date______________

NFPCi 20541

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

		Yes	No
1.	Are you under medical treatment now? If yes, please explain ______________	❑	❑
2.	Have you ever been hospitalized for any operation or serious illness within the last 5 years? If yes, please list ______________	❑	❑
3.	Are you taking any medication(s) including non-prescription medicine? If yes, please list ______________	❑	❑
4.	Have you ever been required to take a preventative antibiotic for dental treatment? If yes, for what condition ______________	❑	❑
5.	Do you use tobacco?	❑	❑
6.	Do you use controlled substance?	❑	❑
7.	Are you allergic to or have you had any reactions to the following:		
	Local Anesthetics (eg. Novacaine)	❑	❑
	Penicillin or any other Antibiotics	❑	❑
	Sulfa Drugs	❑	❑
	Barbiturates	❑	❑
	Sedatives	❑	❑
	Iodine	❑	❑
	Aspirin	❑	❑
	Any Metals (eg. Nickel, mercury, etc.)	❑	❑
	Latex Rubber	❑	❑
	Other: ______________	❑	❑
8.	Women Only:		
	Are you pregnant or think you may be pregnant?	❑	❑
	Are you nursing?	❑	❑
	Are you taking oral contraceptives?	❑	❑

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Thyroid Problem	❑	❑	Joint Replacement or Implants	❑	❑
Heart Attack	❑	❑	Heart Disease	❑	❑	Hepatitis	❑	❑
Rheumatic Fever	❑	❑	Cardiac Pacemaker	❑	❑	Jaundice	❑	❑
Swollen Ankles	❑	❑	Heart Murmur	❑	❑	Sexually Transmitted Diseases	❑	❑
Fainting/Seizures	❑	❑	Angina	❑	❑	Stomach Troubles/Ulcers	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Stroke	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Hay Fever/Allergies	❑	❑
Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Tuberculosis	❑	❑
Leukemia	❑	❑	Mitral Valve Prolapse	❑	❑	Radiation Therapy	❑	❑
Diabetes	❑	❑	Liver Disease	❑	❑	Glaucoma	❑	❑
Kidney Disease	❑	❑	Osteoporosis	❑	❑	Other ______________	❑	❑
AIDS or HIV Infection	❑	❑	Arthritis	❑	❑			

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

		Yes	No
1.	Do your gums bleed while brushing or flossing?	❑	❑
2.	Are your teeth sensitive to hot or cold liquid/foods?	❑	❑
3.	Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4.	Do you feel pain to any of your teeth?	❑	❑
5.	Do you have any sores or lumps in or near your mouth?	❑	❑
6.	Have you had any head, neck or jaw injuries, or jaw pain?	❑	❑
7.	Do you have frequent headaches?	❑	❑
8.	Do you clench or grind your teeth?	❑	❑
9.	Do you bite your lips or cheeks frequently?	❑	❑
10.	Have you ever had any difficult extractions in the past?	❑	❑
11.	Have you ever had any prolonged bleeding following extractions?	❑	❑
12.	Have you had any orthodontic treatment (braces)?	❑	❑
13.	Do you wear dentures or partials? If yes, date of placement? ______________	❑	❑
14.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑

15. What is most important to you about your dental health? ______________
16. What do you value most about your dental health? ______________
17. What is most important about a relationship with a dentist? ______________
18. If there is anything you could change about your smile what would it be? ______________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that there may be a fee charged for appointments cancelled or missed with less than 48 hours notice.**

X ______________________________ Date ______________

Signature of patient (or parent if minor)

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient #: ______________________ Social Security #: ______________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 healthcare operations.

Notice of Privacy Practices: You 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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:

Contact Person: ______________________________

Telephone: ______________________ Fax: ______________________

E-mail: ______________________________

Address: ______________________________

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.

Include completed Consent in the patient's chart.