PATIENT INFORMATION FORM

PERSONAL INFORMATION (CONFIDENTIAL)					
Last Name First Name Middle Initial			Date of Birth	Gender	Social Security Number
Street Address City State Zip				Home/Cell Phone	
Marital Status (please check one) ☐ M ☐ S ☐ D ☐ W ☐ Under 18		Email Address		Work Phone	
Employer & Employer's Address				Occupation	
Spouse's Last Name First Name Middle Initial			Spouse's Date of Birth	Spouse's Cell Phone	
Spouse's Employer and Employer's Address				Spouse's Work Phone	
Emergency Contact Name and Relationship (other than spouse)				Emergency Contact Phone	
If you are a new patient, how did you hear about us? If it's a friend or relative, please include their name so we can convey our appreciation.					

DENTAL INSURANCE AND FINANCIAL INFORMATION		
Subscriber Name (Primary Insurance)	Subscriber Date of Birth	Subscriber ID Number or Social Security
PRIMARY Insurance Carrier Name	Insurance Carrier Address	
Group Name & Number	Patient Relationship to Subscriber	Insurance Carrier Phone
Subscriber Name (Secondary Insurance)	Subscriber Date of Birth	Subscriber ID Number or Social Security
SECONDARY Insurance Carrier Name	Insurance Carrier Address	
Group Name & Number	Patient Relationship to Subscriber	Insurance Carrier Phone

I consent to be a patient and agree to radiographic and clinical examination. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics, oral surgery, endodontics, fixed and removable prosthodontics, implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I agree to update this information periodically, or as needed.

I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand my treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I may be unsure about.

Signature_____ Date _____

HEALTH HISTORY FORM

Patient Name _____Preferred Name _____Date of Birth_____

Name of Primary Care Physician_____ PCP Phone Number (_____)_____

Most Recent Physical Exam_____ Purpose_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an ALLERGIC reaction to:		
☐ Local anesthetics ☐ Aspirin		
☐ Penicillin ☐ Erythromycin		
☐ Sulfa Drugs ☐ Codeine/other narcotics		
☐ Metals ☐ Latex		
☐ Tetracycline ☐ Other: _____		
3. heart problems, or cardiac stent in last 6 months_____	☐	☐
4. history of infective endocarditis_____	☐	☐
5. artificial heart valve, repaired heart defect (PFO)_____	☐	☐
6. pacemaker or implantable defibrillator_____	☐	☐
7. congenital heart defect_____	☐	☐
8. artificial joint (date_____)_____	☐	☐
9. high blood pressure_____	☐	☐
10. low blood pressure_____	☐	☐
11. stroke_____	☐	☐
12. anemia or other blood disorder_____	☐	☐
13. abnormal bleeding_____	☐	☐
14. hemophilia_____	☐	☐
15. rheumatic or scarlet fever_____	☐	☐
16. emphysema/ sarcoidosis_____	☐	☐
17. tuberculosis_____	☐	☐
18. sleep problems or snore_____	☐	☐
19. asthma/breathing problems_____	☐	☐
20. kidney disease_____	☐	☐
21. thyroid, parathyroid disease, or calcium deficiency___	☐	☐
22. liver disease_____	☐	☐
23. jaundice_____	☐	☐
24. hormone deficiency_____	☐	☐
25. sinus trouble_____	☐	☐
26. stomach or duodenal ulcer_____	☐	☐
27. digestive disorders (gastric reflux)_____	☐	☐
28. osteoporosis/osteopenia (taking bisphosphonates)___	☐	☐
29. arthritis_____	☐	☐
30. glaucoma_____	☐	☐
31. contact lenses_____	☐	☐
32. head or neck injuries_____	☐	☐
33. epilepsy, convulsion, seizures_____	☐	☐
34. neurological problems (if yes, type_____)_	☐	☐
35. herpes, viral infections, or cold sores_____	☐	☐
36. lumps or swelling around the mouth_____	☐	☐
37. High cholesterol or taking statin drugs_____	☐	☐
38. STI/STD_____	☐	☐
39. hepatitis (if yes, type_____)_____	☐	☐
40. HIV/AIDS_____	☐	☐
41. tumor, abnormal growth_____	☐	☐
42. cancer, chemotherapy, radiation therapy_____	☐	☐
43. mental health disorder(s)_____	☐	☐
44. excessive urination_____	☐	☐
45. diabetes (if yes, type I or II)_____	☐	☐
46. frequent headaches or migraines_____	☐	☐
ARE YOU:		
48. presently being treated for any other illness_____	☐	☐
49. aware of a change in your health (fever, new cough)_	☐	☐
50. taking weight management medications (fen-phen)___	☐	☐
51. taking dietary supplements_____	☐	☐
52. often exhausted or fatigued_____	☐	☐
55. FEMALE - are you breast feeding_____	☐	☐
56. FEMALE - taking birth control_____	☐	☐
57. FEMALE - pregnant_____	☐	☐
58. MALE - prostate disorders_____	☐	☐
DO YOU:		
47. use alcohol (per week_____)_____	☐	☐
54. use tobacco (smoke, vape, snuff, or chew)_____	☐	☐

Describe any current medical condition or treatment that may possibly affect your dental treatment (i.e. botox, collagen injections) : _____

_____

List all medications, supplements, and or vitamins taken within the last 2 years

DRUG/DOSAGE	PURPOSE/DATE OF LAST DOSE	DRUG/DOSAGE	PURPOSE/DATE OF LAST DOSE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS.

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

DENTAL HISTORY

Patient Name _____ Referred by _____

How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist_____ Phone Number (_____)_____

Most recent dental exam:_____/_____/_____ Most recent dental x-ray: _____/_____/_____

How long had you been a patient of your previous dentist : _____ Months or Years (please circle)

Most recent dental treatment (other than a cleaning) _____/_____/_____ Type of treatment:_____

I routinely see my dentist every: ☐ 3 months ☐ 6 months ☐ 1 year or longer

What is your immediate dental concern: _____

_____

Please answer Y or N to the following questions:

Personal History			
1.	Are you fearful of dental treatment?	Y	N
	If yes, please rate 1 (not too bad) to 10 (very) _____		
2.	Have you had an unfavorable dental experience?	Y	N
3.	Have you ever had complications from past dental treatment?	Y	N
4.	Have you ever had trouble with local anesthetic (difficulty getting numb)?	Y	N
5.	Have you ever had braces, orthodontic treatment or your bite adjusted?	Y	N
6.	Have you had any teeth removed?	Y	N
Smile Characteristics			
1.	Is there anything about the appearance of your teeth you would change?	Y	N
2.	Have you ever whitened your teeth?	Y	N
3.	Are you self-conscious about your teeth?	Y	N
4.	Have you ever been disappointed with the appearance of previous dental work?	Y	N
Bite and Jaw Joint			
1.	Do you have problems with your jaw joint (pain, clicks, sounds, limited opening)?	Y	N
2.	Do you have problems chewing gum, carrots, bagels, protein bars or other hard foods?	Y	N
3.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N
4.	Are your teeth crowding or developing spaces?	Y	N
5.	Do your front teeth close with your natural bite or must you squeeze to make them fit together?	Y	N
6.	Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	Y	N
7.	Do you clench your teeth in the daytime or make them sore?	Y	N
8.	Do you clench or grind your teeth at night or wake up with sore teeth or jaws?	Y	N
9.	Do you or have you ever worn a bite appliance?	Y	N
Tooth Structure			
1.	Have you had cavities in the past 3 years?	Y	N
2.	Do you frequently have dry mouth or have difficulty swallowing?	Y	N
3.	Do you feel or notice and holes (i.e. pitting, craters) on the biting surface of your teeth?	Y	N
4.	Are any teeth sensitive to temperature, biting, sweets, or do you avoid touching certain areas of your mouth?	Y	N
5.	Do you have any grooves or notches on your teeth near the gumline?	Y	N
6.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	Y	N
7.	Do you get food caught between your teeth?	Y	N
Gum and Bone			
1.	Do your gums bleed when brushing, flossing or eating?	Y	N
2.	Have you ever been treated for gum disease or been told you have bone loss?	Y	N
3.	Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
4.	Is there anyone with a history of periodontal disease in your family?	Y	N
5.	Have you ever experienced gum recession?	Y	N
6.	Have you ever had any teeth come loose on their own, or do you have difficulty eating an apple?	Y	N
7.	Have you ever experienced a burning sensation in your mouth?	Y	N

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

EMAIL ADDRESS:_____

I, (print name) _____, have received a copy of this office's Notice of Privacy Practices.

Under the requirements of HIPAA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have any of your medical/dental information released to family members or friends, please list the individual(s) below:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

You are not required to sign to receive care in our dental office.

How would you like us to communicate with you? Our dental office sends appointment reminders, information about treatment, insurance information, and other communications.

For Phone, Text and Email Communications:

By signing below, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

My preferred method of contact is (check all that apply):

☐ Contact me by phone at: ☐ Home (_____)_____
☐ Cell (_____)_____
☐ Work (_____)_____

☐ Text Me ☐ Email Me ☐ Do Not Contact

Signature:_____ Date: _____

Please contact our office right away if you get a new telephone number.

Office use only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, the receipt could not be obtained due to:

☐ Individual refused to sign
☐ An emergency prevented us from obtaining acknowledgment
☐ Communication barriers prohibited obtaining the acknowledgment

☐ Consent Revoked. Date/Initials: _____/_____

About HIPAA Privacy

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Your Health Information is Protected by Federal Law

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations you doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

How is this Information Protected?

- Covered entities must put in place safeguards to protect your health information
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

What rights does this law give me over my health information? Health Insurers and Providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give our permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with our provider or health insurer
    - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights.

Who can look at and receive your health information? The law sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, our information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing purposes
- Share private notes about your health care

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT, AND RELEASE AGREEMENT

Dental treatment is an excellent investment in your and your family's health and wellbeing. We recognize that long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

- I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge.
- I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier.
- I authorize the assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patients Initials_____

FINANCIAL RESPONSIBILITY

I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options.

CASH, PERSONAL AND BANK CHECKS, AS WELL AS ALL MAJOR CREDIT CARDS. Returned checks will be charged a $35.00 NSF fee on the patient account.

AFFORDABLE MONTHLY PAYMENT PLANS (SUBJECT TO APPROVAL). These are outside financing arrangements specifically designed for dentistry and related specialties – with AFFORDABLE MONTHLY payments.

- **NO initial payment with INTEREST-FREE OPTIONS**
- **Low, fixed rates ranging from 4.0% -12%**
- **NO prepayment penalty, terms up to 60 months**
- **Quick and easy application process with Same Day Approval**

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

CANCELED AND MISSED APPOINTMENTS

I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least twenty-four hours in advance so that another patient may use the time reserved for me. There may be a charge for missed appointments or late cancellations.

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance for the services provided but your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept the assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment, and to the use of same by doctor in scientific papers or demonstrations. I certify I have read, or had read to me, the contents of this form and realize the risks and limitations involved.

_____ _____

Patient/Responsible Party Signature Date Practice Representative Date