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

MEDICATIONS

List medications you are currently taking:

_____

_____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

Have you ever taken Redux? ☐ Yes ☐ No

Have you ever taken Biophosphonate? ☐ Yes ☐ No

When were your last dental xrays?_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ 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_____

☐ **2. DRUGS AND MEDICATIONS** (Initials_____)

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 acknowledgement 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: _____