Date: _____

GETTING TO KN[illegible] / YOU AS OUR PATIENT

Patient Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Cell Phone ( )
Email Address		Birthdate / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ M ☐ F	Drivers License and State
Primary Insurance Company _____	Group _____	Subscriber _____
Secondary Insurance Company _____	Group _____	Subscriber _____

Responsible Party

Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ☐ Self ☐ Spouse ☐ Parent ☐ Employer

Where did you find the Phone Number to this Office? _____

☐ Referred by a friend ☐ Yellow Pages ☐ Relative ☐ Insurance Plan ☐ Welcome Wagon
☐ Other _____ ☐ TV/Radio Ad ☐ Newspaper AD ☐ Direct Mailing ☐ Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

**Signature* *Date* *Relationship to Patient*

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

GETT[illegible]G TO KNOW YOU AS OUR P[illegible]IENT

P. IENTS DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? ☐ Yes ☐ No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(Please check one)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? *Please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee_____ Other_____
16. Y N I smoke or use chewing tobacco. If yes, how much per day? ____ How many years? ____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____
21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type _____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis ("Mono")
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35. Y N History of Drug Addiction
36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN:

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications Which ones?_____

Please list all medications you are currently taking:

Medicine_____ Condition _____
Medicine_____ Condition _____
Medicine_____ Condition _____
Medicine_____ Condition _____

Physician's Name _____ Phone _____
Address_____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____/ ____/ ____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____/ ____/ ____
Doctor's Signature *Date*

X _____/ ____/ ____
Patient's Signature *Date*

X _____/ ____/ ____
If patient is a minor: Parent/Guardian's Signature *Date*

GETT G TO KNOW YOU AS OUR I IENT

General Consent Form

Highlighted areas only please, front and back!

X-rays, Exam, Prophy, SRP, PMP, Irrigation, Arestin
*(initials)*_____

Drugs and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.
*(initials)*_____

Changes In Treatment

I understand that during treatment it is necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canals therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(initials)_____

Removal of Teeth

Alternatives to removal have been explained to me and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph #3. I understand removing teeth doesn't always remove all infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, so of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist if complications arise During or following treatment, the cost of which is my *responsibility*.
*(initials)*_____

Crowns, 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 crowns, bridges, or caps (including shape, fit , size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excess delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.
*(initials)*_____

Endodontics (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 root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it.

*(initials)*_____

Fillings

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required to due additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues , I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.

*(initials)*_____

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly 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 understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of patient_____date_____

Signature of Doctor_____date_____

Notice of Cancellation Policy

It has become a problem in our practice to have patients cancel or reschedule appointments on short notice. This is not fair to patients that need an appointment and are unable to be seen because the schedule is full. In order to minimize this we are asking for your cooperation in giving 48 hour notice. If appropriate notice is not given a $25 cancellation fee will be applied. Should you not show up for an appointment $50 charge will be applied.

Records Request Policy

At times patients will request records. There is no charge for xrays to be emailed to you directly. There is however a charge for a copy of the chart. The charge for this is $20. You will have to fill out a records request and pay monies prior to release of records.

I acknowledge receipt of these policies.

_____ _____

Patient Signature Date

Patient Acknowledgement of Receipt of Dental Materials fact Sheet and Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

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

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices and Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____ _____

Employee Name Office Name

_____ _____

Employee Signature Date