

# Patient Information Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female      Marital Status  Married  Single  Divorced  Separated  Widowed

In case of emergency, who should be notified? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

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Is the patient a Minor?  Yes  No      Full-time Student  Yes  No      Name of School \_\_\_\_\_

Name of Responsible Party: First \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient  Self  Spouse  Parent  Other \_\_\_\_\_

If patient is a Minor, primary residency  Both Parents  Mom  Dad  Step Parent  Shared Custody  Guardian

Address: (if different from patient) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work Mobile \_\_\_\_\_

Employer (if different from above) \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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## Dental Benefit Plan Information

Primary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Secondary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

## Medical Plan Information

Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_ Deductible Amount \_\_\_\_\_

### Whom may we thank for referring you?

One of our valued patients (name of patient) \_\_\_\_\_

Advertisement \_\_\_\_\_  Local Dental Society \_\_\_\_\_

Our Website \_\_\_\_\_  Other \_\_\_\_\_

### Please list other members of your immediate family who are patients in our practice

\_\_\_\_\_  
\_\_\_\_\_

**Patient Responsibilities:** We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment \_\_\_\_\_ *\*Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

**Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

**If we are a contracted provider with your plan,** you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

**If we are not a contracted provider with your dental benefit plan,** it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

**Scheduling of Appointments:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$ \_\_\_\_\_ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$ \_\_\_\_\_ or deposit to reserve the appointment time again, may be required.

**Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is \_\_\_\_\_

I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is \_\_\_\_\_

I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

**Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. \_\_\_\_\_(initial)

I have read the above and agree to the financial and scheduling terms. \_\_\_\_\_(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

YES / NO (Circle One) \_\_\_\_\_(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. \_\_\_\_\_(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. \_\_\_\_\_(initial)

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Confidential Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

## I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?  
If NO, explain \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain \_\_\_\_\_
4. Yes / No Are you being treated by a physician now?  
If YES, explain \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain \_\_\_\_\_  
Date of last dental exam \_\_\_\_\_ Name of last treating dentist \_\_\_\_\_
6. Yes / No Are you in pain now?  
If YES, explain \_\_\_\_\_

## II. Have you experienced any of the following? (Please circle Yes or No for each)

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |

## III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- |  |  |                                     |
|--|--|-------------------------------------|
| Yes / No Heart disease                   | Yes / No Cosmetic surgery                | Yes / No Eating disorders           |
| Yes / No Family history of heart disease | Yes / No Surgeries                       | Yes / No Osteoporosis               |
| Yes / No Heart attack                    | Yes / No Hospitalization                 | Yes / No Thyroid disease            |
| Yes / No Artificial joint                | Yes / No Diabetes                        | Yes / No Asthma                     |
| Yes / No Stomach problems or ulcers      | Yes / No Family history of diabetes      | Yes / No Hepatitis                  |
| Yes / No Heart defects                   | Yes / No Tumors or cancer                | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs                   | Yes / No Chemotherapy                    | Yes / No Herpes                     |
| Yes / No Rheumatic fever                 | Yes / No Radiation                       | Yes / No Canker or cold sores       |
| Yes / No Skin disease                    | Yes / No Arthritis, rheumatism           | Yes / No Anemia                     |
| Yes / No Hardening of arteries           | Yes / No Emphysema or other lung disease | Yes / No Liver disease              |
| Yes / No High blood pressure             | Yes / No Kidney or bladder disease       | Yes / No Eye disease                |
| Yes / No Seizures                        | Yes / No Stroke                          | Yes / No Transplants                |
|  |  | Yes / No Tuberculosis               |

**This information will not be released unless specifically authorized by patient.**

Yes / No AIDS/HIV      Yes / No Anxiety      Yes / No Depression      Yes / No Treatment for emotional condition

## IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- |  |                       |                        |
|--|-----------------------|------------------------|
| Yes / No Aspirin                                     | Yes / No Valium       | Yes / No Tetracycline  |
| Yes / No Darvon                                      | Yes / No Demerol      | Yes / No Vicodin       |
| Yes / No Codeine                                     | Yes / No Penicillin   | Yes / No Percodan      |
| Yes / No Latex                                       | Yes / No Food         | Yes / No Nitrous oxide |
| Yes / No Local anesthetic<br>(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal         |

Others \_\_\_\_\_



# Dental Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

What are your goals in coming to our practice today? \_\_\_\_\_

What is important to you in a dentist or dental practice? \_\_\_\_\_

What has been your experience with the dentist in the past? \_\_\_\_\_

Date of last radiographs (x-rays) and exam \_\_\_\_\_

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you left your previous dentist, what are the reasons? \_\_\_\_\_

Have you had problems with prior dental treatment? \_\_\_\_\_

Are you experiencing any pain now?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been pre-medicated for dental treatment?  Yes  No

If yes, why? \_\_\_\_\_

Have you been anxious about having dental treatment?  Yes  No

If yes, would you be comfortable sharing why? \_\_\_\_\_

Would you like to discuss this concern with the doctor to learn about your relaxation options? \_\_\_\_\_

What concerns do you currently have with your oral health or smile? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain                 | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite                         | <input type="checkbox"/> Food gets caught in between teeth              |
| <input type="checkbox"/> Discolored teeth               | <input type="checkbox"/> Underbite                        | If yes, where? _____  |
| <input type="checkbox"/> Crowding/Crooked teeth         | <input type="checkbox"/> Uncomfortable bite               | <input type="checkbox"/> Difficulty chewing                             |
| <input type="checkbox"/> Missing teeth                  | <input type="checkbox"/> Old fillings (gold or silver)    | If yes, where? _____  |
| <input type="checkbox"/> Spaces in between teeth        | <input type="checkbox"/> Old crowns                       | <input type="checkbox"/> Bad breath                                     |
| <input type="checkbox"/> Loose tooth/teeth              | <input type="checkbox"/> Speech problems                  | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Tooth shape or size            | <input type="checkbox"/> Too much gum tissue when I smile |   |

Have you ever had orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?  Yes  No

If yes, when? \_\_\_\_\_

Have you whitened your teeth in the past?  Yes  No

If yes, what method? \_\_\_\_\_

Are you interested in learning more about the following? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening       | <input type="checkbox"/> Tooth-colored fillings             | <input type="checkbox"/> At-home oral hygiene care                  |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants                    | <input type="checkbox"/> Periodontal treatment during pregnancy     |
| <input type="checkbox"/> Veneers               | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |