380 Family Dentistry

Going the extra mile for your family's smile

Getting To Know You As Our Patient

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security No. Driver's License No.	Birthdate
Cell Phone	Email	Sex (Circle One): Male Female
Work Phone	Marital Status (circle one): Single Married Divorced Other	Contact Preferences (circle all that apply) Email Text Phone

Insurance: ☐ **I have secondary insurance. (Please ask us for the secondary insurance form)**

Primary Insurance Company	Group No.	ID No.

Insurance Subscriber Information (if different from patient):

Name	Home Address	City, State, Zip
Home Phone	Social Security No.	Birthdate
Cell Phone	Driver's License No.	Sex(Circle One): Male Female
Work Phone	Email	Relation to Patient:
Employer	Marital Status (circle one): Single Married Divorced Other	Occupation

Responsible Party (if different from above):

Name:	Birthdate:
Social Security No.	Driver's License No.

How did you hear about our office? _____

Communication and Release

I hearby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities.
I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment. I understand if I miss or cancel an appointment with less than 48 hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

_____ _____

Patient/Parent/Responsible Party (I have read and agree to the content, terms, and conditions listed above) Date

Patient Name:_____

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through use of my social security number and any other information given.

I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35.00 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

☐ **I do not agree to the content above and/or do not want to disclose my SSN**. I realize this is my choice and I can still get treatment here. I do understand this comes with the following changes: 1) all treatment will need to be paid in full at time of service, 2) insurance will reimburse me and not my dentist, 3) I must pay with credit card or cash, 4) no payment arrangements will be possible, and 5) often insurance cannot be verified and estimates will be less accurate.

_____ _____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient

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Medical History

Patient Name:_____

Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:

Y N Heart attack	Y N Implant or Artificial Joint	Y N Autoimmune Disease	Y N Kidney or Liver Problems
Y N Chest Pain / Angina	When? _____	Y N Difficult Staying Awake	Y N Epilepsy or Seizures
Y N Pacemaker	Y N Anemia or Blood Disorder	Y N Fatigue	Y N Asthma/Inhaler use
Y N Heart Value Disorder	Y N Excessive Bleeding	Y N Headaches or Migraines	Y N Tuberculosis, Lung Problems
Y N Stroke	Y N Depression	Y N Head/Neck/Jaw Pain	Y N Hepatitis A B C D
Y N High Blood Pressure	Y N Anxiety	Y N Fainting or Blackouts	Y N AIDS or HIV Infection
Y N Dry Mouth	Y N Reflux, Ulcers, Heartburn	Y N Tobacco / Vaping use	Y N Thyroid Disease
Y N Mouth Breather	Y N Difficult Swallow/Chewing	Y N Drug/Alcohol Dependency	Y N Sleep Apnea / Snoring
Y N Cancer/Radiation/Chemo	Y N Diabetes 1 2 Gestational	Y N Endometriosis / Fibroids	Y N Car Accident
	HBA1C? _____	Y N Head Injury / Fall	Y N COPD

Autoimmune Disorders **Please circle all that you have been diagnosed with:**

Hypo/Hyper Thyroid	Celiac	Hashimoto's	Vasculitis	Addison's	Diabetes	Sjogren's
Rheumatoid Arthritis	Lupus	Graves	Psoriasis	Other_____		
RELATED SYMPTOMS	Fatigue	Swelling	Dry Mouth	Joint Pain	Numbness/Tingling	Malaise

(Women) Are you currently pregnant? _____ If yes, when are you expecting? _____

Y N Has your physician advised you to take antibiotics before dental treatment? Reason: Heart Hip Other_____

Do you have any family history of: (circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

Have you had any surgeries or been hospitalized in the last 5 years? □ Yes □ No

If yes, please explain: _____

Physician's name and phone: _____

Circle if allergic to: penicillin antibiotics sedatives latex codeine metals mint other_____

Please list any drugs, medications, or vitamins you are currently taking:

Responsible Party Signature: _____ Date: _____

Doctor/Hygienist Signature: _____ Date: _____

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Dental History

Patient Name:_____

Reason for today's visit: _____ _____ _____

How often do you routinely see the dentist? ☐ 3 months ☐ 4months ☐ 6months ☐ Not routinely

Please rate your anxiety/fear of dental treatment: ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10(or more)

How you had an unfavorable dental experience? ☐ Yes ☐ No

Ever had complications with past dental treatment? ☐ Yes ☐ No

Ever had trouble getting numb or had any reaction to anesthetic? ☐ Yes ☐ No

Do you have an immediate dental concern? ☐ Yes ☐ No If yes: _____

Bite and Jaw Joint

Do you have any problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)	☐ Yes ☐ No
Do you have any problems chewing bagels, protein bars, or other hard foods?	☐ Yes ☐ No
Have your teeth changed in the last 5 years, become shorter, thinner, or worn out?	☐ Yes ☐ No
Are your teeth crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite and squeeze to make your teeth fit together?	☐ Yes ☐ No
Do you have any problems with sleep, or wake up with an awareness of your teeth or jaw?	☐ Yes ☐ No
Have you ever worn a bite appliance?	☐ Yes ☐ No

Smile Characteristics

Is there anything about the appearance of your teeth you would like to change?	☐ Yes ☐ No
Would you like your teeth whiter?	☐ Yes ☐ No
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐ Yes ☐ No
Have you been disappointed with the appearance of previous dental work?	☐ Yes ☐ No

Tooth Structure

Have you had any cavities in the last 3 years?	☐ Yes ☐ No
Does your mouth feel dry or do you have difficulty swallowing food?	☐ Yes ☐ No
Do you feel or notice any holes, pits, or craters in your teeth?	☐ Yes ☐ No
Are your teeth sensitive to hot, cold, biting, or sweets?	☐ Yes ☐ No
Do you avoid brushing any part of your mouth?	☐ Yes ☐ No
Do you have grooves or notches on your teeth near the gum line?	☐ Yes ☐ No
Do you frequently get food caught between your teeth?	☐ Yes ☐ No

Gum and Bone

Do your gums bleed or are they painful when you brush or floss?	☐ Yes ☐ No
Have you ever been treated for gum disease or told you have lost bone?	☐ Yes ☐ No
Have you ever noticed an unpleasant taste or odor in your mouth?	☐ Yes ☐ No
Is there anyone in your family with a history of periodontal disease?	☐ Yes ☐ No
Have you ever experienced gum recession?	☐ Yes ☐ No
Have you ever had teeth become loose (without injury) or have difficulty eating?	☐ Yes ☐ No
Have you ever had a burning sensation in your mouth?	☐ Yes ☐ No

Signature of Patient, Parent, or Guardian: Date: