Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

YOUR RIGHTS TO PRIVACY OF DENTAL RECORDS (HIPPA)

You have certain rights to privacy regarding protected health information, as described in the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, as follows:

• You have the right to review our Notice of Privacy Practices at any time.

• We reserve the right to change our Notice of Privacy Policies at any time. If we change our Notice, you may obtain a revised copy by contacting our office.

• This Notice contains a Patient Rights section describing your rights under the law.

• You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine. We are not required to agree to your restriction, but if we do, we shall honor that agreement.

• You have the right to revoke this Consent, in writing signed by you, at any time, and all future disclosures will then cease. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

• We may condition treatment upon the execution of this Consent.

• The individuals to whom we may disclose your information include, but are not limited to, the following: other healthcare providers and their staff members, dental laboratory personnel, and dental insurance company representatives.
By signing this form, you acknowledge the opportunity to review our Notice of Privacy Practices, and you consent to our use and disclosure of protected heath information about you as described above.

_____

Patient's Signature **Date**

_____

Witness

** *If you do not agree to sign this acknowledgement, you must indicate your reason for declining, below.

_____

_____

_____

Patient's Signature **Date**

INFORMATION ABOUT DENTAL TREATMENT

The practice of dentistry is not an exact science. In most cases, treatment will provide the anticipated benefits. Due to individual patient differences, no dentist can predict success with absolute certainty. While not expected, it is possible that unanticipated complications may arise during any procedure. These include but are not limited to the following: diagnostic procedures, injections of anesthetics, restorative treatment such as fillings, inlays, onlays, crowns and bridges, implant-related treatment, root canals, periodontal (gum) treatments, and extractions. Most of the complications that occur are a normal consequence of treatment. Some of the possible complications include but are not limited to the following:

- Swelling, infection, bleeding, fever, nausea.
- Discoloration of the face.
- Mild to severe discomfort.
- Stretching the corners of the mouth resulting in cracking or bruising.
- Sinus involvement.
- Allergic reactions to medications, materials or anesthetic solutions.
- Difficulty opening or closing the jaw.
- Damage to existing dental work.
- Fractured teeth and/or jaw.
- Numbness, burning, itching or tingling of the lips, gums, tongue, or chin.
- Circumstances that require a referral to another health care provider.

In the majority of cases, full recovery occurs within hours or days. In rare instances, symptoms may be prolonged or even permanent. Medications may be prescribed for pain or infection. Directions for taking medications must be followed carefully. Pain medications may cause drowsiness. When taking a prescription pain medication, you should abstain from alcoholic beverages or other drugs (except as directed), and should not drive an automobile or operate equipment that may be hazardous to you or to others. Effects of pain medications may last 24 hours or more after the final dose. If you are a female who is taking birth control pills, it is possible that you could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be appropriate while taking the antibiotic.

CONSENT FOR TREATMENT

I have read the above and I understand that no treatment is without some measure of risk. I have been informed fully of the nature of my dental treatment, the procedures to be utilized, the risks and benefits of treatment, the alternatives to treatment including no treatment, and the necessity for follow-up care. I have had an opportunity to ask any questions I may have in connection with the treatments and to discuss my concerns. I understand that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I hereby authorize Dr. I. Stephen Brown to perform the necessary dental procedures that have been described to me. I further request and authorize him to use his professional judgment and do whatever he deems advisable and necessary as a result of unforeseen circumstances.

_____

Patient's Signature **Date**

_____

Witness Signature **Date**

I affirm that I am not now, nor have I ever taken any drug (Bisphosphonate) for the treatment of Osteoporosis. These include, but are not limited to Fosamax, Actonel, and Boniva. Furthermore, I have never taken any of the intravenous forms of this family of drugs, including but not limited to Aredia and Zometa.

Patient Initials: _____ **Date:** _____