

## Patient Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_  Home  Cell Social Security Number: \_\_\_\_\_

Email: \_\_\_\_\_ Primary Language:  English  Spanish  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Name	Relationship	Phone
------	--------------	-------

What is the reason for your visit / Chief Complaints? \_\_\_\_\_

## Primary Insurance Information

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient Relationship to Subscriber: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Secondary Insurance Information

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient Relationship to Subscriber: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Name of Patient, Parent, Guardian, or Personal Representative (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## Preferred Pharmacy Information

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Street Address: \_\_\_\_\_

## Dental History and Oral Health

Date of last dental visit: \_\_\_\_\_ Date of last dental X-ray: \_\_\_\_\_

Have you ever been treated for periodontal disease?  Yes  No Have you ever had Novocaine / other local anesthetic?  Yes  No

On a scale of 1 (not happy) to 10 (very happy), how happy are you with your smile? \_\_\_\_\_

Please check any dental conditions that apply to you:

- Pain in Jaw (TMJ)       Teeth Grinding / Clenching       Use Tobacco Products       Swollen / Bleeding Gums  
 Mouth Sores       Broken / Loose Teeth       Sensitive Teeth       Difficulty Chewing / Swallowing  
 Crooked / Spaced Teeth       Tooth Color / Appearance

Are you in pain?  Yes  No      Do you experience any fears or anxieties related to dental treatment?  Yes  No

If Yes, please explain: \_\_\_\_\_

Do you need to be pre-medicated before dental treatment?  Yes  No

## Medical History

Primary Care Provider (Name and Phone): \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Are you taking birth control?  Yes  No  Not Applicable

Are you currently pregnant or nursing?  Yes  No  Not Applicable      Estimated due date, if applicable: \_\_\_\_\_

Please list any prior hospitalizations or surgeries, including dates: \_\_\_\_\_  
\_\_\_\_\_

Is the patient currently using alcohol or drugs (including tobacco)?  Yes  No

If yes, Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_

Do you require antibiotics prior to dental procedures?  Yes  No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years?  Yes  No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)?  Yes  No      If yes, for how long? \_\_\_\_\_

Are you allergic or have you ever had an adverse reaction to any of the following?

- None       Amoxicillin       Aspirin       Codeine       Epinephrine       Latex       Ibuprofen  
 Metals       Penicillin       Sulfa       Tetracycline       Erythromycin       Z-pack

Please specify any other known allergies: \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates

**Conditions (Please check all that apply)**

- None
- Alcoholism
- Allergies or Hives
- Anemia
- Arthritis
- Artificial Joints  
Type & Age: \_\_\_\_\_
- Aspirin Therapy
- Asthma
- Blood Thinners
- Blood Transfusion
- Breathing Problems
- Cancer  
Type: \_\_\_\_\_
- Chemotherapy
- Coumadin Therapy
- Dementia
- Diabetes  
Type: \_\_\_\_\_
- Drug Addiction
- Epilepsy
- Excessive Bleeding
- Fainting / Dizziness
- Hearing Impairment / Loss
- Heart Murmur
- Heart Surgery  
Type: \_\_\_\_\_
- Heart Trouble  
Type: \_\_\_\_\_
- Hepatitis  
Type: \_\_\_\_\_
- High Blood Pressure
- HIV
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Lung Disease / COPD
- Lupus
- Mitral Valve Prolapse
- Mobility Impairment
- NON-DENTAL Implants  
Type: \_\_\_\_\_
- Organ Transplants  
Type: \_\_\_\_\_
- Pacemaker
- Psychiatric Care
- Radiation Therapy
- Radiosurgery
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Sinus Problems
- Stomach Problems
- Stroke
- Thyroid Disease
- Tuberculosis (TB)
- Ulcers
- Visual Impairment
- Other Disease / Illness  
Type: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Drugs and Medication**

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 (severe allergic reaction).  
(Initial: \_\_\_\_\_)

**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 once they've been discovered and discussed.  
(Initial: \_\_\_\_\_)

**X-Rays**

I understand x-rays are necessary for proper diagnosis and treatment.  
(Initial: \_\_\_\_\_)

**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 expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling.  
(Initial: \_\_\_\_\_)

**Local Anesthetic**

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial: \_\_\_\_\_)

**I understand that dentistry is not an exact science, and 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, and my questions have been answered to my satisfaction. I consent to the proposed treatment.**  
(Initial: \_\_\_\_\_)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. In general terms, the dental procedure(s) can include is not limited to:
  - a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride
  - b. Application of resin "sealants" to the grooves of the teeth
  - c. Treatment of diseased or injured teeth with dental restorations (fillings)
  - d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections
4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

**I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient or Parent | Guardian Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT FORM**

I have received the “**Notice of Privacy Practices**” and have been provided an opportunity to review it.

\_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_

Patient Date of Birth

\_\_\_\_\_

Parent | Guardian Name if Patient is a Minor (Print)

\_\_\_\_\_

Relationship to Patient

\_\_\_\_\_

Signature

\_\_\_\_\_

Date