



Patient Information

FULL NAME _____ (PREFERRED NAME) _____ M F
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK _____ EXT _____ CELL _____
SS # _____ DATE OF BIRTH _____ CIRCLE ONE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
EMPLOYED BY _____ OCCUPATION _____
IF COLLEGE STUDENT, NAME OF SCHOOL _____ CITY _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE # _____

Spouse Information

SPOUSE FULL NAME _____ BIRTHDATE _____ SOCIAL SECURITY # _____
SPOUSE EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

Responsible Party

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK _____ EXT _____ CELL _____

Dental Insurance

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
SOCIAL SECURITY# _____ DATE OF BIRTH _____ DATE EMPLOYED _____
EMPLOYED BY _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____
INSURANCE COMPANY _____ GROUP # _____ POLICY # _____
INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

Additional Dental Insurance

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
SOCIAL SECURITY# _____ DATE OF BIRTH _____ DATE EMPLOYED _____
EMPLOYED BY _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____
INSURANCE COMPANY _____ GROUP # _____ POLICY # _____
INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR)

DATE

Adult Medical History



PATIENT FULL NAME _____ DATE OF BIRTH _____ CELL _____

NAME OF FAMILY MEDICAL PHYSICIAN _____ DATE OF LAST MEDICAL EXAM _____

DO YOU HAVE OR HAVE EVER HAD?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach Trouble/Ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial/Damaged Heart Valves | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Radiation Therapy | OTHER: _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | _____ |

ARE YOU UNDER MEDICAL TREATMENT NOW?.....Y N EXPLAIN _____

ARE YOU CURRENTLY TAKING PRESCRIPTION MEDICATIONS.....Y N
PLEASE LIST _____

HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESSES WITHIN THE LAST 5 YEARS?
EXPLAIN _____

HAVE YOU HAD A JOINT REPLACEMENT OR IMPLANT?.....Y N DO YOU USE ALCOHOL?.....Y N
IF SO, WHEN? _____ IF SO, HOW MANY TIMES PER DAY? _____

DO YOU USE TOBACCO PRODUCTS?.....Y N DO YOU USE RECREATIONAL DRUGS?.....Y N
IF SO, HOW MANY TIMES PER DAY? _____ IF SO, HOW MAY TIMES PER DAY? _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?
ANTIBIOTICS (I.E. SULFA DRUGS).....Y N LATEX/RUBBER.....Y N
PLEASE LIST _____ LOCAL ANESTHETIC (I.E. NOVOCAINE).....Y N
ASPIRIN.....Y N PLEASE LIST _____
IODINE.....Y N SEDATIVES.....Y N

OTHER ALLERGIES PLEASE LIST _____

WOMEN ONLY:
ARE YOU PREGNANT OR THINK YOU MAY BE.....Y N ARE YOU NURSING.....Y N
ARE YOU TAKING ORAL CONTRACEPTIVES.....Y N

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 during the period of such dental care to third party payers and /or health practitioners. I agree to notify the office of any health changes that may occur during the year.

SIGNATURE

DATE

Dental History



NAME _____ DATE OF BIRTH _____

DATE OF LAST DENTAL CLEANING & EXAMINATION? _____ X-RAYS _____

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?.....Y N
IF YES, FOR WHAT? _____

ARE YOU CURRENTLY IN PAIN?.....Y N

HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL
WORK?.....Y N

HAVE YOU EVER HAD GUM TREATMENT?.....Y N

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR
JAW JOINT (TMJ / TMD)?.....Y N

HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH IS: GOOD FAIR POOR

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?.....Y N
EXPLAIN _____

DO YOUR GUMS BLEED?.....Y N

HOW MANY TIMES A WEEK DO YOU FLOSS? _____ HOW MANY TIMES A DAY DO YOU BRUSH? _____

TYPE OF BRISTLES? SOFT MEDIUM HARD

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING IT? _____

ARE YOUR TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE? _____

HAVE YOU LOST ANY TEETH? YES NO IF YES, WHY? _____

ADDITIONAL COMMENTS: _____

SIGNATURE

DATE



Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- * Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- * Obtaining payment from third party payers (e.g. my insurance company);**
- * The day-to-day healthcare operations of our practice.**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name _____ Signature: _____

Relationship to Patient: _____

Office Policies

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Please take a moment to review our office and financial policies.

Appointments

Upon arrival, please sign in and let the receptionist know you are here. Please update any changes in your address, phone numbers, or insurance information.

Your appointment time is reserved for you. We confirm appointments as a courtesy to our patients, 48 hours prior to the appointment. We ask that you also give us 48 hours' notice if you need to change your appointment.

Late arrivals of greater than 10 minutes may be asked to reschedule their appointment(s).

All minors must be accompanied by a parent or guardian as we need your permission to treat them.

This office uses ambient listening to record treatment discussed between the dentist and the patient.

In order to complete a thorough examination, diagnosis and treatment plan current x-rays are necessary. We try to keep the X-rays up to date by taking bitewings once a year and the Panoramic X-ray once every five years. New patients are required to have all of the X-rays completed at their first visit. If your insurance does not cover the X-rays at your first appointment we will write them off so there will not be a charge for you.

Missed appointments or no-show appointments will be charged a \$50.00 fee.

Insurance

I authorize and request my insurance company to pay directly to Forestville Dental

As a courtesy to our patients, we do file your insurance for you. However, it must be stressed that your insurance is a contract between you, your employer and the insurance company. We will do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc.

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 dependents.

Treatment Plans

An estimate will be provided for all treatment plans.

For patients who have insurance, an Estimate will be given of the benefits that the insurance company is expected to pay. Any co-payment is expected at the time services are rendered. Treatment plans are subject to change. In the event of any changes patient will be advised.

Payment Options

We accept Cash, Check, MasterCard, Visa, Discover.

Sign: _____ Date: _____