
## *Patient Information*

**FULL NAME**_____ **(PEFERRED NAME)**_____ **M F**

**ADDRESS**_____ **CITY**_____ **STATE**_____ **ZIP**_____

**HOME PHONE**_____ **WORK**_____ **EXT**_____

**EMAIL**_____ **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*

FORESTVILLE DENTAL

**PATIENT FULL NAME**_____ **DATE OF BIRTH**_____

**EMAIL**_____ **CELL**_____

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

**DO YOU HAVE OR HAVE EVER HAD?**

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

IF SO, WHEN?_____

**DO YOU USE ALCOHOL?**.....Y N

IF SO, HOW MANY TIMES PER DAY?_____

**DO YOU USE TOBACCO PRODUCTS?**.....Y N

IF SO, HOW MANY TIMES PER DAY? _____

**DO YOU USE RECREATIONAL DRUGS?**.....Y N

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

PLEASE LIST_____

ASPIRIN.....Y N

IODINE.....Y N

LATEX/RUBBER.....Y N

LOCAL ANESTHETIC (I.E. NOVOCAINE).....Y N

PLEASE LIST_____

SEDATIVES.....Y N

OTHER ALLERGIES PLEASE LIST _____

**WOMEN ONLY:**

ARE YOU PREGNANT OR THINK YOU MAY BE.....Y N

ARE YOU TAKING ORAL CONTRACEPTIVES.....Y N

ARE YOU NURSING.....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*

FORESTVILLE DENTAL

**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***

Forestville Dental, 7535 State Road Unit M, Cincinnati, Ohio 45255 (P) 513-231-5444 (F) 513-231-8135

FORESTVILLE
DENTAL

## *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:_____

FORESTVILLE DENTAL

## 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 committed to providing superior dental care at reasonable prices and are 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 notify us of any changes to your address, phone number, or insurance information.

Your appointment time is reserved specifically for you. As a courtesy, we confirm appointments 48 hours in advance. We ask that you also provide us with at least 48 hours' notice if you need to reschedule or cancel your appointment. Patients arriving more than 10 minutes late may be asked to reschedule their appointment. All minors must be accompanied by a parent or legal guardian, as we require consent to provide treatment.

This office uses ambient listening technology to document treatment discussions between the dentist and the patient. To complete a thorough examination, diagnosis, and treatment plan, current X-rays are necessary. We strive to keep your X-rays up to date by taking bitewing X-rays once a year and a panoramic X-ray once every five years. New patients are required to have all necessary X-rays completed at their first visit. If your insurance does not cover the X-rays at your initial appointment, we will write off the balance so there will be no charge to you. Missed appointments or no-show appointments will be charged a $50.00 fee.

## Insurance

I authorize and request my insurance company to pay benefits directly to Forestville Dental. As a courtesy to our patients, we file insurance claims on your behalf. However, please understand that your insurance policy is a contract between you, your employer, and your insurance company. While we will do our best to help you receive your maximum benefits, we cannot become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary fee determinations, or other coverage issues.

I understand that my dental insurance carrier may pay less than the actual cost of services provided. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

## Treatment Plans

An estimate will be provided for all treatment plans. For patients with dental insurance, an estimate of the benefits expected to be paid by the insurance company will be provided. Any estimated patient co-payment is due at the time services are rendered. Treatment plans are subject to change. If any changes become necessary, the patient will be informed before treatment proceeds.

**Patient/Guardian:**_____ **Date:** _____