dental32

Patient Information

PLEASE PRINT

Circle One: Dr / Mr / Mrs / Ms / Miss

Today's Date: _____

Name: _____

Date of Birth: _____

Preferred Name: _____

Sex (please circle): Male Female

Social Security Number: _____

FOR BILLING PURPOSES ONLY

Street: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____

May we contact you at work? Yes No

Email Address: _____

May we contact you by email? Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell: _____ Work Phone: _____ Home Phone: _____

INSURANCE INFORMATION

Do you have dental insurance? (circle) Yes No

Primary Insurance		Secondary Insurance (if applicable)	
Subscriber Name		Subscriber Name	
Subscriber SSN#		Subscriber SSN#	
Date of Birth		Date of Birth	
Relationship to Subscriber (circle)	Self Spouse Child Other	Relationship to Subscriber (circle)	Self Spouse Child Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present card and driver's license to administrative assistant to be photocopied			

Medical Health History

Patient Name: _____ Date of Birth: _____
Primary Care Physician (PCP): _____ PCP Phone #: _____
Primary Care Physician Address: _____

DO YOU HAVE OR HAD, ANY OF THE FOLLOWING?	YES
Heart Problems	
▪ Chest pain	
▪ Shortness of breath	
▪ Blood pressure problem	
▪ Heart murmur	
▪ Heart valve problem	
▪ Rheumatic fever	
▪ Pacemaker	
▪ Artificial heart valve	
Blood Problems	
▪ Easy bruising	
▪ Frequent nosebleeds	
▪ Abnormal bleeding	
▪ Blood disease (anemia)	
▪ Ever require a blood transfusion?	
Allergy Problems	
▪ Hay fever	
▪ Sinus problems	
▪ Skin rashes	
▪ Asthma	
Intestinal Problems	
▪ Ulcers	
▪ Special diet	
▪ Constipation/Diarrhea	
▪ Kidney or bladder problems	
Bone or Joint Problems	
▪ Arthritis	
▪ Back or neck pain	
▪ Joint replacement (e.g., total hip, pins, or implants) o If so, how long ago?	
Fainting Spells, Seizures, or Epilepsy	
Stroke(s)	
Frequent or severe headaches	
Thyroid problems	
Persistent cough or swollen glands	
Premedication's required by physician	
Cancer/Tumor	
Diabetes	
Tuberculosis or other respiratory disease	
Do you drink alcohol?	
▪ If so, how much?	
Do you smoke?	
▪ If so, how much?	
Hepatitis, jaundice, or liver trouble	
Herpes or other STD	
HIV-positive/AIDS	

DO YOU HAVE OR HAD, ANY OF THE FOLLOWING?	YES
Glaucoma	
Do you wear contact lenses?	
History of head injury?	
History of alcohol or drug abuse?	

Are you allergic, or have you reacted adversely, to any of the following?	YES
Local anesthetics (Lidocaine, etc)	
Penicillin or other antibiotics	
Sulfa Drugs	
Barbiturates, sedatives, or sleeping pills	
Aspirin, acetaminophen, or ibuprofen	
Codeine, Demerol, or other narcotics	
Reaction to metals	
Latex or rubber	
Other:	

PLEASE LIST ALL CURRENT MEDICATIONS

WOMEN ONLY	YES
Are you taking contraceptives or other hormones?	
Are you pregnant?	
▪ If so, expected delivery date:	
Are you nursing?	
Have you reached menopause?	
• If so, do you have symptoms?	

Patient Signature: _____
Dentist Signature: _____
Date Signatures Obtained: _____

Dental Health History

Previous Dentist: _____ How long ago was last visit? _____

What is your immediate dental concern?

_____

How often do you have your teeth cleaned? (Please circle) 3 months 6 months 1 year or more

How often do you brush your teeth? _____ Floss? _____

Rate your smile from 1 to 10 (with 10 being the best): _____

YES	PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES:
	Do you have sensitive or sore teeth?
	Do your gums bleed?
	Do you have an unpleasant taste or odor in your mouth?
	Have you previously had treatment for gum disease (periodontal disease / pyorrhea)?
	Have you previously had orthodontic treatment (braces)?
	Do you currently wear any type of appliance?
	Do you have jaw problems (TMJ problems)?
	Do you have jaw clicking or popping?
	Does your jaw ever lock?
	Do you have difficulty opening your mouth widely?
	Do you have tension headaches?
	Do you awaken with an awareness of your teeth or jaws?
	Are you aware of clenching or grinding your teeth?
	Do you have any lumps or swelling in your mouth?
	Do you have difficulty swallowing or pain with swallowing?
	Do you have a dry mouth?
	Do you frequently have mouth sore (cold sores, canker sores)?
	Have you lost any teeth?
	Do you have unfavorable previous dental experiences?
	Do you have anxiety about dental visits?
	Do you sweat or tremble a lot during examination?
	Have you had problems with effectiveness of dental anesthetic?
	Are you unhappy with the appearance of your teeth/gums/smile?
	Would you like to discuss how to make your teeth whiter?

If I need dental treatment, I would like:

	a warm blanket
	noise-reducing headphones
	laughing gas (nitrous oxide)
	a sedative to completely relax me

I Prefer:

	shorter, multiple appointments
	longer appointments to get as much done as possible at one time

SUPPLEMENTAL DENTURE HISTORY (Please fill out if you are wearing a partial or complete denture)

YES	PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES:
	Has your present denture been relined? If so, when?
	Is your present denture a problem? Please Describe:
	Satisfied with the appearance?
	Satisfied with the comfort?
	Satisfied with the chewing ability?

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____ Doctor's Signature _____Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dental 32 has the right to change its Notice of Privacy Practices from time to time and that I may contact Dental 32 at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient's Parent/Guardian Name (if applicable): _____

Signature of Patient (or Parent/Guardian of patient): _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's/patient guardian's signature to acknowledge receipt of the Notice of Privacy Practices but was unable to do so as documented below.

_____

Date Employee Initials Reason

Disclosure and Consent for Use of Health Information

I, _____, do hereby grant permission for Dental 32 to disclose my personal health information to the following personal representative(s):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Information to be disclosed (please check all that apply):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office

_____

Signature of Patient Date

(Parent/legal Guardian if Patient is a minor)

Consent for Use

In providing the best treatment for our patients, it might be necessary for Dental 32 to email x-rays to other specialists or dentist. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

_____

Signature of Patient Date

(Parent/legal Guardian if Patient is a minor)

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Written Financial Policy

Thank you for choosing Dental 32 for your oral healthcare needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal dental care as affordable and manageable for you as possible. We do this by offering several payment options.

Payment Options:

- Cash, Check, Visa, MasterCard, or Discover Card
  - For patients who do not have insurance support, we offer a 5% accounting courtesy to patients who pay with cash or check.

- CareCredit Healthcare Credit Card[1] – convenient monthly payment option
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

Please Note:

- Dental 32 is a service provider just like any other business, therefore, we require payment in exchange for treatment at the beginning of each and every appointment. Fees paid for the portion of treatment completed are not refundable.

- As a courtesy for patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

- It is important that we have 24-hour notice in the event you need to reschedule your appointment in order to avoid a broken appointment, late notice, or no show fee ($50.00).

- Consecutive missed and/or rescheduled appointments could result in patient dismissal from our office.

- Dental 32 charges $34.00 for returned checks.

- If you have questions, please do not hesitate to ask. We are here to help you receive the dentistry you want and need.

_____

Printed Patient Name

_____

Signature of Patient (Parent/legal Guardian if Patient is a minor) Date

[1] Subject to credit approval.

[2] If we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.