Name	Employer
Address	Primary Dental Insurance Co.
City Zip Code	Group #
Phone Birth date	Employee
Who will pay for this account?	Secondary Dental Insurance Co
Who may we contact in case of emergency?	Group#
	Employee
Medical doctor	
Pharmacy Preference	

Please list any prescription and over the counter Medications that you take on a regular basis

Please circle Yes or no to indicate if you have had any of the following conditions:

Yes	No	High or low Blood pressure	Yes	No	Ulcers
Yes	No	Congenital Heart Defect	Yes	No	Cold sores
Yes	No	Heart Murmur	Yes	No	AIDS
Yes	No	Pace maker or Internal Defibrillator	Yes	No	HIV Positive
Yes	No	Artificial Heart Valve	Yes	No	Abnormal Bleeding
Yes	No	Cardiac Stent	Yes	No	Cancer or Leukemia
Yes	No	Heart Attack	Yes	No	Radiation Therapy
Yes	No	Chest Pains	Yes	No	Chemotherapy
Yes	No	Rheumatic Fever	Yes	No	Organ Transplant
Yes	No	Arthritis	Yes	No	Stroke
Yes	No	Osteoporosis or bone disorders	Yes	No	Epilepsy or Seizures
Yes	No	Medications for Osteoporosis or bone disorders	Yes	No	Frequent headaches
Yes	No	Artificial Joint, Pin or Implant	Yes	No	Migraine Headache
Yes	No	Antibiotics before Dental Treatment	Yes	No	Blood Thinners or Aspirin
Yes	No	Tuberculosis	Yes	No	Unexplained Fever
Yes	No	Asthma	Yes	No	Sinus Trouble

Yes	No	Frequent Cough	Yes	No	Prolonged Sore Throat
Yes	No	Liver Disease	Yes	No	Swollen Lymph Nodes
Yes	No	Hepatitis or Jaundice	Yes	No	Fainting
Yes	No	Spleen Removal	Yes	No	Tobacco Use
Yes	No	Kidney Problems	Yes	No	Substance Abuse
Yes	No	Diabetes	Yes	No	Allergies to Drugs or Medications
Yes	No	Thyroid Condition			**If Yes, Please list below**

Please list any condition or illness not listed above?

Are you Pregnant? Yes No Due Date______________________________

Are you taking birth control pills Yes No

Yes No Have you ever been told you have gum disease?

Yes No Do you clench or grind your teeth?

Yes No Do you have difficulty opening your mouth wide.

Yes No Is there anything you would like to change about the look or feel of your teeth? If yes, please Explain:

Signature/Date

Signature/Date

OFFICE INSURANCE POLICY

This office accepts multiple insurance plans to help patients with the cost of dental care. As a courtesy, we do assist the patient with understanding his or her coverage. However, it is **NOT** our responsibility to review the status of coverage or breakdown of each individual's coverage. The patient is responsible to communicate with the office about any insurance changes or updates. **If there are any insurance issues or complications, the patient must resolve the problem with their insurance company**. The patient is responsible for any unpaid balances within an appropriate time period. A finance charge will be applied to any late payments.

I have read and fully understand the above office insurance policy

Name:____________________________________ Date:__________________________

OFFICE FINANCIAL POLICY

I understand that payment is due on the day of service. I understand the office reserves the right to charge me **$50.00 for a missed or broken appointment without 24 hour notice**. I understand I am responsible for any unpaid balances on my account. A finance charge will be applied to any late payments.

Print name____

Sign name____

Date____

General Consent for Treatment and Local Anesthesia

While serious complications associated with dental procedures are very rare, we would like you to be informed about *necessary procedures* in dentistry and your consent before beginning treatment. The following risks and or complications exist with dental treatments.

Complications: resulting from the use of dental injections and anesthetics include and are not limited to:

- Swelling at site of injection
- Bleeding at site of injection
- Infection at site of injection
- Discomfort at site of injection
- Prolonged numbness and tingling sensation in oral cavity. These sensations are usually temporarily, but can be permanent
- Jaw muscle cramps and spasms
- Jaw joint difficult or pain radiating to head, neck and ear
- Nausea and vomiting
- Allergic reaction
- Rapid or irregular heartbeat
- Biting of the cheek, lip and tongue after treatment resulting in swelling and discomfort

Complications: from medications or prescription medication given in the office are common. To decrease your risk of a potentially serious drug reaction, please provide us with the knowledge of any past drug allergies or adverse reactions. In addition to, we are careful about the medications we prescribe and will not prescribe a medication unless it is absolutely necessary:

- Allergic reaction- itching, swelling, difficulty breathing
- Adverse reactions- nausea, vomiting, headache, drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth are soreness of the gums in the area that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to call our office.

I have read and understand this form and give general informed consent for dental treatment.

________________________________ ________________

Patient's signature Date

ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE READ/BEEN OFFERED A COPY OF THIS DENTAL PRACTICE'S HIPAA NOTICE OF PRIVACY PRACTICES.

PATIENTS NAME: ____________________________

PATIENTS SIGNATURE: ____________________________

DATE: _____________

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: ____________________________

AUTHORITY OF PERSONAL REPRESENTATIVE TO SIGN FOR A PATIENT (CHECK ONE)

PARENT ___ GUARDIAN ___ POWER OF ATTORNEY ___ OTHER ___