Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you!

Name: ____________________ **Nickname:** ______________________________

SSN: ____________________**Cell:** ______________________________

Email: ____________________ **Home:** ______________________________

Mailing Address: ____

City: ______________ **State:** ____________ **Zip:** __________ **Sex: M___ F___**

DOB: ______________ **Single ___ Married ___ Divorced ___ Separated ___ Widowed ___**

Emergency Contact: ______________________ **Phone:** ______________

How did you hear about our office? ______________________________

If insured, please provide dental insurance card

DENTAL HISTORY

Previous Dentist: ______________________ **Phone:** ______________

Immediate Dental Concerns: ______________________________________

- **Do you gums bleed when you brush?** Y N
- **Do your gums ever feel swollen & tender?** Y N
- **Have you ever had periodontal disease?** Y N
- **Does food catch between your teeth?** Y N
- **Do you grind your teeth at night?** Y N
- **Do you have sensitivity?** Y N
- **Do you have popping/pain in your jaw?** Y N
- **How often do you brush a day?** Once Twice More
- **How often do you floss?** Daily Weekly More

Are you satisfied with the appearance, shape and color of your teeth? Y N

Have you ever had a professional smile consultation? Y N

Have you ever worn braces or Invisalign? Y N

Have you ever tried teeth whitening? Y N

Do you wish to have flouride treatment? Y N

Are you allergic to any of the following?

Penicillin Latex Codeine Sulfa Drugs Aspirin Erythromycin

Are you currently under physician's care? ____________________ **Name:** ______________________

(If yes, please explain): ______________________________ **Number:**__________________________

Your current health: Good___ Fair ___ Poor ___ Are you on a special diet? ___________________

Do you smoke, use tobacco or vape? ____

Do you take, or have taken Phen-Fen or Redux? ____

Have you taken Fosamax, Actonel, Boniva or any other bisphonspanates? ____________________

Have you had a knee and/or hip replacement? ____

Are you taking any prescription or over the counter herbal supplements?

____

Please circle any that apply to you:

Y N AIDS/ HIV POSITIVE
Y N Alzheimer's Disease
Y N Anaphylaxis
Y N Anemia
Y N Angina
Y N Arthritis/ Gout
Y N Artificial Heart Valve
Y N Artificial Joint
Y N Asthma
Y N Blood Disease
Y N Blood Transfusion
Y N Breathing Problems
Y N Bruise Easily
Y N Cancer
Y N Chemotherapy
Y N Chest Pains
Y N Cold Sores / Fever Blisters
Y N Congenital Heart Disorder
Y N Heart Trouble
Y N Pace Maker

Y N Cortisone Medicine
Y N Diabetes
Y N Drug Addiction
Y N Easily Winded
Y N Emphysema
Y N Epilepsy or Seizures
Y N Excessive Bleeding
Y N Excessive Thirst
Y N fainting spells/ Dizziness
Y N Frequent Cough
Y N Frequent Diarrhea
Y N Frequent Headaches
Y N Genital Herpes
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Failure
Y N Heart Murmur
Y N Parathyroid Disease
Y N Psychiatric Care

Y N Hospitalized for any Reason
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B or C
Y N Herpes
Y N High Blood Pressure
Y N High Cholesterol
Y N Hives or Rash
Y N Hypoglycemia
Y N Irregular Heartbeat
Y N Kidney Problems
Y N Leukemia
Y N Liver Disease
Y N Low Blood Pressure
Y N Lung Disease
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Pain in Jaw/Joints
Y N Ulcers

Y N Radiation Treatments
Y N Recent Weight Loss
Y N Renal Dialysis
Y N Rheumatic Fever
Y N Rheumatisim
Y N Scarlet Fever
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Trouble
Y N Spina Bifida
Y N Stomach Disease
Y N Stroke
Y N Swelling of Limbs
Y N Thyroid Disease
Y N Tonsillitis
Y N Tuberculosis
Y N Tumors or Growths
Y N Convulsions
Y N Yellow Jaundice

FOR WOMEN: Are you using a prescription method of birth control? Y N

Are you pregnant? Y N **Are you nursing? Y N**

Have you ever had any serious illness, or serious head or neck injury not listed?

____

Signature: ____ **Date:** __________________

Prior to scheduling dental treatment (other than an exam, x-rays, and cleaning appointments) payment is collected in full.

We offer the following financial options. Please let us know if you have any questions.

1. **We accept Cash, Check, Visa, MasterCard, American Express and Discover Cards.**
2. **Care credit: For treatment over $250.00. You can apply online or in office and approval is relatively quickly. Payments can be stretched up to 24 months. There is no down payment required, no annual fees and no pre-payment penalty for this plan.**
3. **Lending Club: For treatment over $499.00. You can apply online or in office and approval is also known quickly. Payments can be stretched over 6-84 months. There is no upfront payment and first payment is not due for 3-7 weeks. This plan also offers no pre-payment penalties.**
4. **Dental Insurance: We are happy to submit your dental claims to your carrier. Please know that variables exist (i.e. deductibles, annual maximums, allowable fee limitations, non-coverage procedures and other restrictions). Therefore, we cannot guarantee any estimated charges. Most dental insurance plans do not cover 100% of your cost of treatment. Because your insurance is an agreement between you and your insurance company, ultimately you are responsible for all coverage and any outstanding balance.**

Patient Name: ____

Signature:______________________ **Date:** __________________

HIPAA CONSENT FORM

HIPAA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed: ______________________________

This consent was signed by: ______________________________ (PRINT NAME PLEASE)

Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________