Patient Information Form

Patient Information

Name ______________________________________ SSN ______________
Last Name First Name Initial

Address ______________________ City __________ State _____ Zip _______

Home Phone __________ Cell Phone __________ Email ______________

Sex M F Age _____ Birthdate ________ Driver's License # ______________

Single Married Widowed Separated Divorced Spouse Name ______________

Employer ____________ Occupation ____________ Work Phone ____________

Work Address ______________________ Work Email ______________

Preferred Contact Method *(circle one)* Email Text Call Cell Call Home Call Work

Whom may we thank for referring you? ______________________________

Notify in case of emergency ______________________ Relationship ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Email ____

Primary Dental Insurance

Insurance Company ______________________ Employer ______________

Insurance Phone ____________ Insurance Email ______________________

Policy Holder ______________________ SSN ____________ Birthdate ________

Contact # ____________ Group # ____________ Subscriber # ____________

Names of other dependents under this plan ______________________________

Secondary Dental Insurance

Insurance Company ______________________ Employer ______________

Insurance Phone ____________ Insurance Email ______________________

Policy Holder ______________________ SSN ____________ Birthdate ________

Contact # ____________ Group # ____________ Subscriber # ____________

Names of other dependents under this plan ______________________________

Medical Insurance

Insurance Company ______________________ Employer ______________

Insurance Phone ____________ Insurance Email ______________________

Policy Holder ______________________ SSN ____________ Birthdate ________

Contact # ____________ Group # ____________ Subscriber # ____________

Names of other dependents under this plan ______________________________

Patient's Name | Date of Birth | Height | Weight | Date

Physician's Name | Phone Number

Dental History

Please Circle

Date of Last X-Rays & Exams ________ **Date of Last Teeth Cleaning** ________

What concerns do you currently have with your smile? (circle all that apply)

Unhappy with appearance of teeth	Speech problems	Tooth space or size	Old crowns
Uneven gum lines	Crowding/Crooked teeth	Discolored teeth	Too much gum tissue when I smile
Old Fillings (Gold or Silver)	Spaces in between teeth	Missing teeth	

Are you experiencing any pain now? ________

If yes, please describe ________

How often do you brush/floss? ________

What else do you use to clean your teeth? ________

Do you have a specific dental problem? If yes, what is it? ________ Yes No

Does food catch between your teeth? Any loose teeth? Where? ________ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ________ Yes No

Do you wear a bite appliance? (TMJ, grinding guard, sleep apnea or snoring) ________ Yes No

Have your past experiences in a dental office always been positive? ________ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss: ________ Yes No

Medical History

Are you under a physician's care now? Discuss: ________

Have you ever been hospitalized or had a major operation? Discuss: ________

Have you ever had a serious injury to your head or neck? Discuss: ________

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? Which ones and what strength? ________

____

____

____

Do you use a CPAP? Do you snore? ________ Yes No

Have you been diagnosed with Sleep Apnea, had a sleep study when? ________ Yes No

Are you allergic to any medications or substances? Please check:

Local Anesthesia(Novacain, etc.)? ________ Yes No	Latex or Rubber Products? ________ Yes No
Penicillin or other antibiotics? ________ Yes No	Metal of any kind? ________ Yes No
Sedatives, Barbiturates? ________ Yes No	Chemicals or jewelry (rash or sensitivity)? ________ Yes No
Aspirin or Ibuprofen? ________ Yes No	Food products? ________ Yes No
Codeine or other pain killers? ________ Yes No	Other allergies or reactions? Please List ________

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ________

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

Do you now have or have you ever had any of the following? Do you take any of these medications? Please check appropriate boxes below.

If yes to any of the starred conditions, please call prior to your appointment. Premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Acid Reflux	☐	☐	Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hypoglycemia	☐	☐	Frequent Headaches	☐	☐
Heart Disease/Surgery*	☐	☐	Anemia	☐	☐	Cancer	☐	☐	Liver Disease	☐	☐	Migraine Headaches	☐	☐
Heart Murmur or Defect*	☐	☐	Coronary Stent*	☐	☐	Radiation Treatments	☐	☐	Hepatitis A(Infectious)	☐	☐	Herpes	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Hepatitis B or C	☐	☐	Stroke	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Protease Inhibitor	☐	☐	Convulsions	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia	☐	☐	Biphosphonates	☐	☐	Night Sweats	☐	☐	Epilepsy or Seizures	☐	☐
Congenital Heart Disorder*	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Yellow Jaundice	☐	☐	Fainting or Dizziness	☐	☐
Mitral Valve Prolapse*	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Kidney Problems	☐	☐	Glaucoma	☐	☐
Scarlet Fever	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Renal Dialysis	☐	☐	Tumors or Growths	☐	☐
Rheumatic Fever*	☐	☐	Swelling Limbs	☐	☐	Fosamax, Actonal, Boniva	☐	☐	Thyroid Disease	☐	☐	Nervousness	☐	☐
Artificial Heart Valve*	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal	☐	☐	Parathyroid Disease	☐	☐	Psychiatric Care	☐	☐
Heart Pace Maker*	☐	☐	Breathing Problem	☐	☐	Disease	☐	☐	Arthritis/Gout	☐	☐	Alzheimer's Disease	☐	☐
Pulmonary Shunt*	☐	☐	Shortness of Breath	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Allergies(Medicines)	☐	☐
High Blood Pressure	☐	☐	Frequent Cough	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Allergies(Pollen/Dust)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Need premedication?	☐	☐
Bacterial Endocarditis*	☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Artificial Joint	☐	☐	Ever taken fen-phen?	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Excessive Thirst	☐	☐	Sexually Transmitted Disease	☐	☐	Cochlear Implants	☐	☐

Have you ever had any other serious illness not checked above? ________ Yes No **Discuss:** ________

Do you wish to talk to the dentist privately about any problem? ________ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ________ **Date:** ________

PATIENT SIGNATURE (PARENT/GUARDIAN)

Reviewed by Doctor: ________ **Date:** ________ **BP:** ________ **Pulse:** ________

PERSONAL CONTRACTS

1) MISSED APPOINTMENT CONTRACT. I understand that if I fail to appear on time for my appointment as scheduled without giving the office 48 hour notice: 1) There may be a cancellation fee 2) I will be required to prepay for the next appointment or 3) by my request as an alternative, I will be placed on a will-call list.

Initial ______

2) CANCELLATION CONTRACT. I understand that if I am unable to keep an appointment, I must give 48 hour notice. Otherwise I will be charged for the time reserved, if my appointed time cannot be filled.

Initial ______

3) DENTAL INSURANCE. We promise to make every effort to maximize your insurance reimbursement. I understand that Dr. Greg Don is a third party in the insurance-patient relationship. I acknowledge that my estimated portion is due at the time of service.

Initial ______

4) COLLECTIONS. I understand that ultimately I am responsible for all dental care fees, regardless if the insurance denies payment or the procedure is not a covered benefit. I accept the responsibility for all dental care fees. I accept the responsibility for any reasonable collection and /or legal charges incurred in the recovery of these fees.

Initial ______

5) Patient Acknowledgement of receipt of Dental Materials Fact Sheet:
I ____________________________ acknowledge I have received a copy of the Dental Materials Fact Sheet from Dr. Greg Don.

____

Patient's Signature Date

PATIENT RELEASE FORM

Patient's Last Name First Name MI

1) CHANGES IN TREATMENT PLAN. I understand that as treatment progresses it may be necessary to change or add procedures due to conditions found during the process of treatment that were not readily evident at the exam and diagnosis phase of treatment and of which could require care by a specialist, the cost of which is my responsibility. I give my consent to these changes or additions. I understand that even minor treatment can result in sensitivity and even a routine procedure can necessitate root canal therapy.

Initial ______

2) MEDICATIONS & ANESTHETICS. I understand that antibiotics, analgesics, anesthetics, medications and other dental supplies / products may be part of treatment and can cause allergic reactions (redness, swelling, pain, itching, vomiting and/or anaphylactic shock) and can change the effectiveness, duration and interact with other medications taken. The injection of anesthetic can cause temporary or indefinite changes in feeling (parasthesia) and motor control.

Initial ______

3. REMOVAL OF TEETH (EXTRACTION). Alternatives to the removal of teeth have been explained to me as applicable (root canal therapy, crowns, periodontal surgery - etc) and I authorize the removal of Treatment Planned teeth and any others necessary (see paragraph #1). I understand the risks include pain, swelling, discomfort, the spread of infection, dry socket, parasthesia, (a change in feeling in my teeth, lips, tongue and surrounding areas that can be permanent in nature) and/or changes in motor control. I understand removing teeth does not always remove all of the infection and infection caused changes. These and other complications that may occur during or following treatment may require further treatment by a specialist or even hospitalization, the cost of which is my responsibility.

Initial ______

4) ROOT CANAL (ENDODONTIC TREATMENT). I understand that a root canal is an attempt to save a tooth and that complications (calcified canals, inaccessible canals, perforation & loss of the canal during treatment, instrument separation in the canal and/or fracture of the tooth crown, body or root) can occur. Other complications can include a reaction to a medication used, pain, swelling, continued infection and sensitivity to pressure even after treatment is completed. These and other complications that may occur during or following treatment may require further treatment (including retreatment, surgery on the root and/or extraction) by a specialist, the cost of which is my responsibility.

Initial ______

5) FILLINGS. I understand that as treatment progresses, as in any restorative procedure, the cavity (caries) may be greater than expected.

Initial ______

6) INLAYS, VENEERS, CAPS (CROWNS) AND BRIDGES. I understand that it is not possible to exactly match the color of natural teeth. I realize that the time to request changes (in color, shape, fit and size) is prior to cementation. I realize that permanent crowns are fabricated from materials that can be susceptible to fracture. I understand that the temporary placed interim to the placement of the permanent is fragile in nature and care must be taken not to break or dislodge it. The temporary is constructed to last only two to three weeks; postponing the placement of the permanent can allow tooth movement, necessitating a remake at an additional charge.

Initial ______

7) DENTURES-COMPLETE OR PARTIAL. I understand problems in wearing dentures can include looseness, sore spots, decreased ability to speak/eat and breakage. Immediate dentures (dentures placed at the time of the extractions) have more discomfort and require additional adjustments. I realize that the time to request changes (in color, shape, fit, and size) is at the "teeth in wax" visit. Relines (at an additional fee) will be required as a denture loosens with tissue shrinkage.

Initial ______

8) GUM (PERIODONTAL) TREATMENT. I understand that I have a serious and progressive disease that can lead to acute infection, pain and tooth loss. Treatment can include cleanings (scaling), deep cleanings (root planing), periodontal surgery (by referral to a specialist) and teeth considered hopeless or teeth that do not respond favorably to treatment will require extraction . I understand that post-therapy my teeth may be sensitive to cold and sweets. I understand that postponement of care and other factors including the quality of home care can affect my ability to retain my natural dentition.

Initial ______

9) Implants. I understand that implants have two main parts: an abutment (root form) and a restoration (suprastructure) portion. Poor healing or infection at the surgical site can lead to acute infection, pain and loss of the abutment and/or adjacent teeth. The restorative portion also may come lose or fracture requiring replacing screws or collars, recementation and/or complete loss of the suprastructure. Replacement of the abutment or suprastructure are additional procedures, the cost of which is my responsibility. I understand that smoking greatly increases the risk of abutment failure.

Initial ______

I understand that dentistry is as much an art as a science and because of this it is impossible to predict the outcome of treatment. I authorize my treating dentist(s) to proceed through the use of medications, materials and therapy as deemed appropriate as treatment progresses. I have no unanswered questions about treatment benefits/risks, or alternative treatment(s) and their benefits / risks I have read, understand and agree to the above.

Patient's Signature Date

Greg Don DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
Other (Please Specify)

____
____
____
____
____

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).