

Patient Information

Patient Name: _____ **Date:** _____
Last First MI Preferred Name

Gender: Male Female **Family Status:** Married Single Child Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Cell):** _____ **(Work):** _____ **Ext:** _____

E-mail Address: _____

Address: _____
Street

City State Zip Code

Employer: _____

Occupation: _____

Employer's address: _____

Person to contact for emergency: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Insurance Information

PRIMARY

Insurance Plan Name and Phone#: _____

Policy Holder's name: _____

Patient's relationship to Policy Holder: _____

Policy Holder's Birth Date: _____ Member ID#: _____ Group#: _____

Policy Holder's Address: _____

Policy Holder's Employer Name: _____

SECONDARY- (if applicable)

Insurance Plan Name and Phone#: _____

Policy Holder's name: _____

Patient's relationship to Policy Holder: _____

Policy Holder's Birth Date: _____ Member ID#: _____ Group#: _____

Policy Holder's Address: _____

Policy Holder's Employer Name: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient (relative, friend) Google

Dental Office Insurance Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor or staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.

I understand that I can ask for a complete recital of any complications.

Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Medical History and Health Information

Patient's Name: _____ **Date of Birth:** _____

If you are completing this form for another person:

Your name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ **Phone:** _____

Date of last physical examination: _____

If you are a new patient to this practice:

Date of last dental visit: _____ Dentist's name: _____ City & State: _____

1. Within the last 3 years, have you been hospitalized or had surgery? Yes No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*? Yes No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or having treatments currently? Yes No

Prescribed/ Over-the-Counter/Vitamins (If you brought a complete written list with you, give it to the Front Desk):

Are you having or have you ever had radiation or chemotherapy treatments*? Yes No

If Yes, for how long? _____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? Yes No

5. Have you had an allergic reaction or unusual response to any medications, drugs, pills, substance or treatments? Yes No

If Yes, please list : _____

6. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No		Yes	No
Any Heart Condition, Surgery, Disease	—	—	Raspatory illness/condition	—	—
If yes, type& date _____					
Angina or chest pains	—	—	Sinus problems	—	—
Atherosclerosis	—	—	Tuberculosis, emphysema or lung disorder	—	—
Coronary artery disease	—	—	A thyroid problem or disease	—	—
Pacemaker	—	—	Arthritis	—	—
Stroke or CVA	—	—	Glaucoma or any eye diseases	—	—
High blood pressure	—	—	Epilepsy or other seizure disorder	—	—
Low blood pressure	—	—	Any mental health issues	—	—
Anemia	—	—	Any eating disorder	—	—
Hemophilia or bleeding disorder	—	—	Ulcers, acid reflux, or stomach problems	—	—
Excessive bleeding from any cut or incident	—	—	Currently pregnant or nursing	—	—
Diabetes or blood sugar problems	—	—	A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	—	—
Any artificial joint, joint surgery, or prosthesis	—	—	An active sexually transmitted disease (STD)	—	—
If Yes, when and what joint or area: _____					
Hepatitis, jaundice, or other liver problems	—	—			
Any organ transplant	—	—			
Any form of cancer	—	—			
Any kidney problems	—	—			
Any skin problems	—	—			

7. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No

If Yes, please explain: _____

Dental and Oral Health Information

Patient's Name: _____ Date of Birth: _____

Please describe any specific dental problem or discomfort you are having at this time: _____

How long has it been present: _____

1. If you have had any of the following dental care please list dentist and dates:

Periodontal (gum) treatment or surgery: _____

Braces or any type of orthodontic treatment: _____

Dental implants: _____

Any other type or oral surgery: _____

2. How many times a day do you brush your teeth? _____ How many times do you floss your teeth: _____

Do you use any electric toothbrush, Waterpik, Mouthwash, flossing aids? Yes No

If yes, please specify which: _____

3. Do you have any missing teeth? Yes No

If yes, please specify why have not had them replaced: _____

4. Do you wear any removable dental appliances? Yes No

If Yes, what type and how long : _____

5. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No	Yes	No
Sensitive teeth (hot, cold, sweets, biting pressure) If yes, specify: _____	___	___	TMJ concerns (jaw difficulties, clicking, snapping when chew)	___ ___
An unpleasant taste or persistent bad breath	___	___	Difficulty moving your tongue or tongue tied	___ ___
Food Trap between your teeth	___	___	Pain, tenderness, numbness or earaches	___ ___
Any Gum concerns (red, swollen, bleeding, sore, pulled away from teeth)	___	___	Any lumps, swelling or swollen glands	___ ___
Clenching or grinding teeth	___	___	Sores, ulcers or rough spots in your mouth	___ ___

6. How do you feel about the appearance of your smile and what would you change if you could?

7. Have you ever had any complications from an extraction or dental treatment? Yes No

If yes, please explain: _____

8. Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth? Yes No

If yes, please specify: _____

9. Do you smoke or have you ever smoked? Yes No

(If no, proceed to next question)

The amount that you are presently smoking: _____

If you quit smoking, when did you quit? _____

How many years have you or did you smoke? _____

10. Have you ever chewed tobacco or used snuff or other similar substances? Yes No

(If no, proceed to next question)

Are you still using smokeless tobacco or snuff? Yes No

If no, when did you quit? _____

How many years did you use or have you used smokeless tobacco? _____

11. Do you consume any alcoholic beverages? Yes No

If yes, approximate amount per week: _____

12. Have you ever had a substance abuse problem, or do you presently use any recreational drugs? Yes No

If yes, please specify: _____

CONSENT — To the best of my knowledge, all the preceding information is correct and if there is ever any change in health or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above-named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____

Financial Policy Carmel West Dentistry

Acceptable forms of payment include cash, check, credit card (Master Card, Visa, American Express and Discover) or Care Credit.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will file the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If assignment of dental benefits is accepted by this office, then all co-pay and deductibles are due at time of service. I understand that if insurance has not paid on my behalf within 60 days of service, then the remaining balance is due immediately by me, or my responsible party.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that a charge of \$50.00 will be assessed to my account in the event of failure to notify this office of cancellation of an appointment 48 hours prior to scheduled time.

I understand that checks returned for insufficient funds will result in an additional charge of \$35.00 being assessed to my account.

I agree that any unpaid balance shall accrue interest at the rate of 18% per year. We reserve the right to place an unpaid account with a collection agency. In that event, I agree to be responsible for the unpaid balance, collection fees equaling 25% of the unpaid balance placed for collection, interest at the rate indicated in this paragraph, and any other costs of collection. Additionally, if an attorney is used by the collection agency to pursue collection of the account, I also agree to be responsible for all reasonable attorney fees, court costs, and sheriff service fees or other service of process fees.

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above and agree to its content.

Signature of Patient, Parent or Guardian:

Date:

Signature of guarantor of
payment/responsible party (if other than above):

Date:

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 Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify):

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Communication Methods

You may contact me via the following methods: (Please check all that apply)

___ Cell phone; ___ text; ___ calls

___ Email

___ Work phone

___ Home Phone

Consent for Internet Communications

I grant my permission to Carmel West Dentistry to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for Carmel West Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Carmel West Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Carmel West Dentistry is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Carmel West Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Carmel West Dentistry web site with my ID and password. I also agree to immediately notify Carmel West Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Carmel West Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Carmel West Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Carmel West Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Carmel West Dentistry CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Carmel West Dentistry, and grant Carmel West Dentistry permission to securely upload my patient information to the web site.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____
(if applicable)

My signature above also authorizes the following people to be informed of &/or have access to my dental information and records :

Name: _____ Relationship: _____

Name: _____ Relationship: _____