

Patient Information

Email: _____

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> STD | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |

Please list all prescriptions and/or over the counter medications you are currently taking:

• **Are you taking any type of blood thinners?** Yes No

If yes, please list medicine name: _____

• **Have you ever had any complications following dental treatment?** Yes No

If yes, please explain: _____

• **Have you been admitted to a hospital or needed emergency care during the past two years?** Yes No

If yes, please explain: _____

• **Are you now under the care of a physician?** Yes No

If yes, please explain: _____

• **Name of Physician:** _____ **Phone:** _____

• **Do you have any health problems that need further clarification?** Yes No

If yes, please explain: _____

• **EMERGENCY CONTACT:** _____ **Phone:** _____
RELATIONSHIP: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Signature of Doctor _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient (friend) Another patient (relative)
 Internet Insurance Newspaper Postcard Other _____
Name of person or office referring you to our practice: _____

HIPAA

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please print name

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

I give you permission to share my personal information with my Dental Insurance Company and the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

No Show/Broken Appointment Policy

We recognize that everyone's time is valuable; patients and doctors alike. For that reason, we request at least a 48-hour notice if you must cancel an appointment. Failure to make an appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment. We also understand that emergencies happen and will do our best to accommodate you in any way that we can in case of such emergency.

If you accumulate 3 cancellations with less than 48-hours' notice or 3 "no show" appointments within the course of a 6-month period, you will be required to pay 100% of your patient portion upon scheduling any restorative appointment.

Thank you for your consideration and understanding of your oral health and the doctor's time.

Patient Initials: _____

Dental Warranty

Protect your smile

We Stand Behind What We Do. Peace of Mind Limited Dental Warranty

Patient Name: _____

We are proud of our dental services and what they do for our patients. Our goal is not to overly correct your dental problems, but have the work we do last for many years into the future, to save you time and to save you from unnecessary expenses, and in addition, show you how to prevent dental disease in the future. The long term success of our dentistry is directly dependent on: How well you care for your teeth at home, eating a sensible diet and adhering to the schedule we set for you for the frequency of your professional examinations, cleaning and fluoride treatments. The products we recommend for you and the frequency of professional continuing care visits depends on your individual situation.

With these thoughts in mind, we are pleased to offer the following limited dental warranty:

Sealants

If our dental sealants are in need of repair with normal use during a period of two (2) years from the date of initial placement, we will replace or repair them at no additional charge.

Composite (tooth colored) Fillings

If a composite filling is the *recommended* treatment of choice, we will replace or repair it in the event of a failure for a period of two (2) years. Composite restorations done as a *compromised* form of treatment (instead of a crown, inlay, onlay or veneer) are not covered under this warranty. If the restoration itself (NOT THE REMAINING TOOTH STRUCTURE) breaks or fractures within two (2) years and requires a crown, or onlay, we will credit any out of pocket expense for the filling towards the additional service.

Root Canals

Root Canals are 95% successful but not 100%. If you have a root canal and the recommended final restoration for your tooth (post and core and a full coverage crown) and your root canal fails within two (2) years we will credit your account your total out of pocket expenses of the root canal toward replacement bridge or implant crown.

Crowns, Bridges, Inlays, Onlays and Porcelain Veneers

We have learned that despite our best efforts, any of these tooth restorations can fail for a variety of reasons that include new decay, breakage from excessive grinding of one's teeth, or simply biting down on a hard object such as a fork, bone, or nut. In fairness to both patient and doctor we will warranty these lab created restorations on a sliding scale of replacement cost in the unlikely event that you should require replacement in the first five (5) years. The percentages reflect **your portion** of the current fees at the time replacement is needed.

First year	0%	Fourth year	60%
Second year	0%	Fifth year	70%
Third year	0%	Sixth+ year	100%

Dentures and Partial

Full Dentures and partial dentures are warranted for a period of two (2) years. Accidents such as dropping your denture are not covered. Due to the nature of dentures, we cannot guarantee your comfort or your ability to accommodate these artificial appliances. They may require additional services such as adjustments or re-lines to maintain. Those are not included as they are considered maintenance. We will not reconstruct, repair, relin or replace the denture free of charge, due to any of the following: loss, discoloration, excessive wear (for example, excessive grinding of teeth), inappropriate use (for example, any use not prescribed by the dentist), neglect or abuse.

CONDITIONS

- You must maintain uninterrupted membership in our practice.
- Keep your prescribed regular continuing care appointments (with no appointment carrying more than 30 days), periodontal and regular cleanings and receive regular professional in-office fluoride treatments at every preventative office visit.
- Maintain your account in good standing.
- Have all recommended treatment(s) performed by one of our doctors, including the use of bruxism guards if recommended.
- This warranty does not include anything not mentioned above, including gum line desensitization, night guards, nor does it cover damage to teeth or dental prostheses caused by accidents, trauma, neglect or improper use (grinding, clenching, chewing ice or biting non-food items)

 **Patient Signature:** _____ **Date:** _____