DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________

Patient ______________________

Address ______________________

____
City State Zip

Sex: ☐ M ☐ F Age ________ Birthdate ________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# ______________________

Occupation ______________________

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Spouse's Name ______________________

Birthdate ____________ SS# ____________

Occupation ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ____________

____

2 DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ N

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance cove
with ____________________ and assign directly to
Dr. ____________________ all insurance benefits, if
otherwise payable to me for services rendered. I understand that I a
financially responsible for all charges whether or not paid by insura
I hereby authorize the doctor to release all information necessary
secure the payment of benefits. I authorize the use of this signature on
insurance submissions.

____
Responsible Party Signature

____
Relationship Date

3 PHONE NUMBERS

Home ____________ Work ____________ Ext. ________ Email ____________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY. CONTACT (Specify someone who does not live in your household.)

Name ____________ Relationship ____________

Home Phone ____________ Work Phone ____________

4 MEDICATIONS

List medications you are currently taking:

____

____

____

Pharmacy Name ______________________

Phone ______________________

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other ____________

☐ Latex ____________

Reason for Today's Visit:

____

____

5 HEALTH HISTORY

Physician's Name ____________________ Date of Last Visit __________

Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Artificial Heart Valves ☐ Yes ☐ No
Artificial Joints ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No
Bleeding Abnormally with Extractions or Surgery ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Circulatory Problems ☐ Yes ☐ No
Congenital Heart Lesions ☐ Yes ☐ No
Cortisone Treatments ☐ Yes ☐ No
Cough, Persistent or Bloody ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No
Fainting or dizziness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Problems ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Type __________
Herpes ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
HIV Positive ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Jaw Pain ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Nervous Problems ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Women: Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Due Date __________

Psychiatric Care ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Skin Rash ☐ Yes ☐ No
Special Diet ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swelling of Feet or Ankles ☐ Yes ☐ No
Swollen Neck Glands ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumor or Growth on Head or Neck ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Unexplained Weight Loss ☐ Yes ☐ No
Hospitalizations/Surgeries __________

6 DENTAL HISTORY

Reason for today's visit __________

Former Dentist __________
City/State __________
Date of last dental visit __________
Date of last dental X-rays __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Blisters on lips/mouth ☐ Yes ☐ No

Burning Sensation on Tongue ☐ Yes ☐ No
Chew on One Side of Mouth ☐ Yes ☐ No
Cigarette, pipe, or Cigar Smoking ☐ Yes ☐ No
Clicking or Popping Jaw ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No
Fingernail Biting ☐ Yes ☐ No
Food Collection Between the Teeth ☐ Yes ☐ No
Foreign Objects ☐ Yes ☐ No
Grinding Teeth ☐ Yes ☐ No
Gums Swollen or Tender ☐ Yes ☐ No
Jaw Pain or Tiredness ☐ Yes ☐ No
Lip or Cheek Biting ☐ Yes ☐ No

Loose Teeth or Broken Fillings ☐ Yes ☐ No
Mouth Breathing ☐ Yes ☐ No
Mouth Pain, Brushing ☐ Yes ☐ No
Orthodontic Treatment ☐ Yes ☐ No
Pain Around Ear ☐ Yes ☐ No
Periodontal Treatment ☐ Yes ☐ No
Sensitivity to Cold ☐ Yes ☐ No
Sensitivity to Heat ☐ Yes ☐ No
Sensitivity to Sweets ☐ Yes ☐ No
Sensitivity when Biting ☐ Yes ☐ No
Sores/Growths in Mouth ☐ Yes ☐ No

How often do you floss? __________
How often do you brush? __________

7 UPDATES

(To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____________________

Are you taking any new medications? __________ If so, what? __________

Parent's Signature ____________________ Date __________

Doctor's Signature ____________________ Date __________

Art of Dentistry Office Policies

- A $25 fee will be assessed on missed appointments with less than a 24 hour notice. Notice is appreciated so we may be able to serve other patients needs.
- All fees are due and payable at the time of your appointment. For your convenience, we accept Cash, Check, MasterCard, Visa, American Express, and Discover.
- As a courtesy, we accept assignment of insurance benefits, allowing you to pay your deductible and/or estimated co payment at the time of treatment. Your insurance policy is a contract between you and your insurance company. We have no control over your insurance company's payment of claims. Any balance left unpaid by your insurance company 60 days after service is due in full by you.
- Our office always tries to maintain quality sterilization procedures for your protection and safety as well as safeguarding our staff. To prevent the increase of our fees to cover the accelerated cost of maintaining these standard, we assess a small office visit charge to continue quality of sterilization protocol you expect and deserve. ($5-$10 in accordance with insurance policies.)
- We reserve the right to assess fees for: Returned Checks $35, Duplication of Dental Images $20, Repeated Statements $10, and Outstanding Collections 6%.
- We provide services on an appointment basis. While we make every effort to be punctual, there will be emergencies or circumstances beyond our control that may delay our appointment schedule. Only one dentist is present to serve your dental needs. Your patience is appreciated.
- Please notify the office staff if you have any special need when you arrive.

The undersigned has read and accepts the above, and agrees to abide by all terms and conditions as stated.

Patient Signature______________________________________ Date____________

Guardian if Child

Consent for Disclosure of Health Care Information

Patient Name: ______________________________ Date of Birth__________

SSN___________________________ Previous Name__________________

My personal health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health care operations.

I understand that my doctor and his/her staff may use and disclose my personal health information help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the releases of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry our treatment, pay or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or his/her staff can give me called "The Revocation of Consent for use and Disclosure of Health Information" or
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

My doctor has a detailed document called "The Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this notice. If asked, the doctor or his/her will provide me with the most current "Notice" and the current "Notice" will always be posted.

My signature below indicates that I have been given the chance to review a current copy of my doctors "Notice of Privacy Policies." My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

____

Patient or Legal Guardian Signature Date

____

Relationship to Patient

Responsibility and Consent Statement

I hereby Authorize and Request the performance of Dental services for:

Name: ________________________________ Age__________

Name: ________________________________ Age__________

Name: ________________________________ Age__________

Name: ________________________________ Age__________

- I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment.
- I understand and acknowledge that I am financially responsible for the services provided for myself or the above named individual, regardless of insurance coverage on the day services are rendered.
- The undersigned has read and accepts the internal policies as set forth by this office, and shall herby agree to abide to all terms and conditions as stated herein.

Patient Signature: ________________________________ Date:______________

Guardian Signature if child

Insurance Notification

- I understand that my insurance policy is a contract between my insurance company and myself, not between the insurance company and Art of Dentistry.
- I also understand that insurance policies vary greatly from one policy to the next and that Art of Dentistry and its staff are not responsible for knowing all the details of my policy.
- I understand that Art of dentistry's staff is authorized to file my insurance as a courtesy to me.
- I agree that my insurance policy is ultimately my responsibility and that if the insurance company does not remit payment within 60 days, the bill for dental services becomes my sole responsibility and I will remit payment and petition the insurance company on my own behalf.

Responsible Party Signature:________________________________ Date:__________

INSTRUCTIONS FOR PATIENTS FOLLOWING ORAL SURGERY

READ AND FOLLOW THESE ADVISORIES FOR MAXIMUM COMFORT AND FEWER PROBLEMS!

1. Bleeding	Keep biting on the gauze(s) for about 2 hours, then remove and throw it/them away. We expect minor oozing for up to 24 hours after surgery. If heavy bleeding continues replace moist gauze over the site(s) and bite for an additional 30-60 minutes
2. Swelling	Some swelling is <u>NORMAL</u> after surgery, and some patients swell more than others. If your doctor expects increased swelling, you will be given an ice pack to place adjacent to the surgery site(s) for the next 6-8 hours. Use the pack 20 minutes off, and so on. Tomorrow start using <u>MOIST HEAT</u> as instructed. (also see #8 below)
3. Medications	Take your medication as instructed, do not drink alcoholic drinks or take other medications without your doctor's permission. Take medications on a full stomach or with a full glass of juice, etc. to lower the chance of getting nauseated. If you do become sick, and it continues, notify your doctor and discontinue medication.
4. Fluids	Drink plenty of fluids for the next few days.
5. Diet	Eat whatever feels comfortable. Soups and soft foods will be more comfortable for a few days. "Diet drinks" (e.g. Carnation Instant Breakfast) are also beneficial.
6. Activity	Remain quiet for 24-48 hours. Avoid running or strenuous activities.
7. Brushing	A clean mouth heals fast, but don't brush the immediate area near the surgery site(s).
8. Mouth Soaks	After 24 hours gently soak your mouth with warm water after each meal, to keep the site(s) clean. You need not add salt to the water.
9. Avoid......	Smoking, alcoholic drinks, peroxide, and commercial mouthwashes for at least 24 hours following surgery, and ideally longer.
10. Sutures	If sutures are place they will dissolve 5-10 days after procedure. Removal is only required if they become untied and dangle down. If <u>SILK</u> sutures are placed they <u>DO</u> require doctor removal 14 days after procedure. Always remember follow up appointments!
11. Problems	If you have any problems of concern about your healing, do not hesitate to call your doctor for advice or return to the office. After hours the doctor may be reached on the emergency pager noted above.