FOUNDATIONS
FAMILY & IMPLANT DENTISTRY

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

1 Basic Information

Patient's name _____ Preferred name _____

Date of Birth _____ Social Security # _____

If minor, parent or guardian name _____

Mailing address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer _____

Spouse's name (if applicable) _____

How would you like to receive appointment reminders? ❑ text ❑ email ❑ phone only

How did you hear about our office? _____

2 Insurance Information

❑ Not covered by dental insurance

Subscriber's Name _____ Subscriber's DOB _____

Subscriber's SS # _____

Dental Insurance Co. _____ Group number _____

Secondary Dental
Insurance Co. _____ Group number _____

NEXT PAGE PLEASE

3 Medical Health History

Do you have or have you had any of the following? (Please check all that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Acid Reflux
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint
- ❑ Asthma
- ❑ Cancer
  - ❑ Diagnosis _____
  - _____
  - ❑ Treatment History _____
  - _____
- ❑ Diabetes
- ❑ Emotional condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Heart ailment or angina
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High blood pressure
- ❑ Hx of congenital heart disease
- ❑ Hx of heart surgery or valve replacement
- ❑ Kidney disease
- ❑ Low blood pressure
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Sinus trouble / Hayfever
- ❑ Smoke / Chewing tobacco
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis or other lung problems

Are you taking any of the following?

- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ **Other Prescription or Over-the-Counter Medications or Supplements (Please List)**

_____
_____
_____
_____
_____

4 Allergies

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Advil - Ibuprofen
- ❑ Aspirin
- ❑ Clindamycin
- ❑ Codeine or other narcotics
- ❑ Latex materials
- ❑ Local anesthetics (“Novocain”)
- ❑ Penicillin or Amoxicillin
- ❑ Sedatives, or sleeping pills
- ❑ Sulfa drugs
- ❑ Tylenol - Acetaminophen
- ❑ Other _____
  _____
  _____
  _____

5 Women

- ❑ Pregnant or Trying to Conceive
- ❑ Taking hormones or contraceptives

If pregnant, how many weeks? _____

NEXT PAGE PLEASE

6 Dental Concerns

Are you? (Please check all that apply)

❑ Experiencing any dental pain? _____

❑ Do you have any TMJ pain or history of surgery? _____

Are you happy with your smile? ❑ Yes ❑ No

If no, what would you change? _____

_____

7 Physician's Information

Physician's Name: _____

Do you have any disease, condition, or problem not listed above? If so, please describe:

_____

_____

Please add anything else you would like us to know about:

_____

_____

Signature of patient
(or parent if under 18) _____ Date____/____/____

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I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

7. I understand that there is a $25.00 fee for not showing up for scheduled appointments. *Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

Signature of patient
(or parent if under 18) _____ Date____/____/____

NEXT PAGE PLEASE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient if under 18 yrs. _____

Name of Signer _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____

Reason: