New Patient Form

Name (First, Middle, Last): _____

DOB:_____ Patient Social Security Number: _____

Phone: _____Email Address: _____

Address: _____

City:_____ State:_____Zip Code:_____

Emergency Contact: _____Phone: _____

Pharmacy Name: _____Pharmacy Phone: _____

Pharmacy Address: _____

How did you hear about us?Google Friend/Family: _____ Other: _____

Insurance Information

Insurance Company: _____ Phone: _____

Member ID #: _____ GROUP #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____Relationship to Policy Holder:_____

Do you have any additional insurance?YesNo

Insurance Company:_____Phone: _____

Member ID #: _____GROUP #: _____ Policy Holder's Name: _____ Policy Holder's DOB: _____

Employer:_____ Relationship to Policy Holder: _____

HEALTH HISTORY FORM

Patient's Name_____**Date of Birth**_____/_____/_____

Gender_____**Height**_____**Weight**_____**Today's Date**_____

An accurate and complete health history will assist in coordinating your dental care.

Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No

If yes, please
describe_____

Are you having any dental discomfort at this time?Yes / No

If yes, please
describe_____

Have you had any adverse effects from dental treatment?Yes / No

If yes, please
describe_____

Date of last dental visit?_____

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums? Yes / No Shifting in bite? Yes / No

Unpleasant taste/bad breath? Yes / No Change in bite? Yes / No

Swelling/lumps in mouth? Yes / No Burning tongue/lips? Yes / No

Orthodontic treatment (braces?) Yes / No Frequent blister, lips/mouth? Yes / No

Clenching/grinding? Yes / No Sensitive teeth (hot or cold?) Yes / No

Sensitive to sweets? Yes / NoClicking/popping jaw? Yes / No

Sensitive to biting? Yes / NoDifficulty opening or closing jaw? Yes / No

Food Impaction? Yes / NoLoose teeth? Yes / No

Biting cheeks/lips? Yes / No

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe:
_____

Are you now under a doctor'scare for a medical condition? Yes / NoDate of last physical exam?_____

If yes, please
describe_____

Name of physician_____Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please
describe_____

Have you ever had surgery? Yes / No

If yes, please
describe_____

_____

_____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease– like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes /No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer? If yes, type_____ Diagnosis date_____ Treatments_____ ____	Yes / No	Osteoporosis or osteopenia?	Yes / No

Do you have any other medical conditions that are important for your doctor to know about? Yes / No

If yes, please describe_____

_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes? Yes / No Relationship_____	Heart disease? Yes / No Relationship_____
Lung disease? Yes / No Relationship_____	Bleeding problems? Yes / No Relationship_____
Cancer? Yes / No Relationship_____	

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No If yes, please describe_____

Medications– Are you currently prescribed or taking any of the following:					
Antibiotics?	Yes / No	Prescription pain medication?	Yes / No		
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No		
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No		
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No		
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No		
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No		

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No		Yes / No

If yes, please describe_____

_____

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ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco?	Yes / No	**Do you use:**	
If yes, for how long? _____		Alcohol? Yes / No If yes, how often per week?_____	
Have you ever sought professional care or been hospitalized for:		Marijuana? Yes / No If yes, how often per week? _____ Recreational drugs? Yes / No If yes, how often per week?_____	
Substance abuse	Yes / No		
Emotional disorders	Yes / No		
Alcoholism	Yes / No		

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care.

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardianDate

_____

Printed name of patient, parent, guardian/Relationship

For office staff use - HEALTH HISTORY REVIEW

DateCommentsDoctor's Signature

_____

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For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment
- By signing this form you are also consenting to our communication by text messaging. (Your information is only being use to discuss treatment, appointment confirmations and in no way is it shared with third party vendors)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice
- The HIPPA Privacy Rule Permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date_____

Print Patient Name _____

Signature_____

Relationship to Patient_____

Financial Policy Consent Form

We welcome you and your family to Preserve Dental. We look forward to providing you with quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you review and complete our financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your dental treatment.

Dental Insurance Benefits: You need to be aware that

We will always do our best to help you maximize your benefits. Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

Your Treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Dental Insurance Claim Payments:

As a courtesy to all our insured patients, we will file your dental insurance claims forms. In some circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for you co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forward immediately to our office so that your account may be credited accordingly.

Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

Payment: FULL Payment is due at the time of the service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

I _____ understand and accept the financial and insurance policies listed above and have had any and all questions answered to my satisfaction.

I_____ agree to pay for all treatments in a timely fashion as described.

I_____ hereby authorize my insurance benefits to be paid directly to Preserve Dental. I realize that I am responsible to pay for any deductible amount(s), my co- insurance portion and for any non-covered services the day of the service. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance. I agree to pay such charges in full.

_____ _____ _____ _____

Patient/Legal Guardian Date Witness Date