

PATIENT INFORMATION FORM



Patient Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Cell Phone: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____
Email: _____

Name of Spouse or Responsible Party: _____ Date of Birth: _____
Cell Phone: _____ Home Phone: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____
Email: _____

Primary Dental Insurance

Name of Insurer: _____ Group Name: _____
Name of Primary Person Covered by this Insurance: _____
Date of Birth of Primary Person: _____ SSN: _____

Secondary Dental Insurance

Name of Insurer: _____ Group Name: _____
Name of Primary Person Covered by this Insurance: _____
Date of Birth of Primary Person: _____ SSN: _____

Tertiary Dental Insurance

Name of Insurer: _____ Group Name: _____
Name of Primary Person Covered by this Insurance: _____
Date of Birth of Primary Person: _____ SSN: _____

Primary Care Provider Name: _____ Phone: _____
Preferred Pharmacy with Location: _____
Referred By (Please Circle): Social Media Friends/Family Google Mailer Billboard Doctor
Drive/Walk By Word of Mouth Doctor: _____ Other: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Medical History

Patient Name _____ Age _____

Please Indicate if you have or have had any of the following. (Place an X to indicate)

- | | |
|---|---|
| <input type="checkbox"/> Taking Blood Thinners | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack - Year _____ | <input type="checkbox"/> Glaucoma Type: _____ |
| <input type="checkbox"/> Heart Infection | <input type="checkbox"/> Osteoporosis Medication / Name: _____ |
| <input type="checkbox"/> Heart Problems/Defect – Type _____ | <input type="checkbox"/> IV Drug Medications - Type _____ |
| <input type="checkbox"/> Born With A Heart Defect – Repaired? Yes No | <input type="checkbox"/> Joint Replacement - Date of Surgery _____ |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Tuberculosis – Cleared by Physician? Yes No |
| <input type="checkbox"/> Heart Surgery - Type _____ | <input type="checkbox"/> History of Drug Dependency |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Tobacco or Vape Use – Type _____ |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Acid Reflux (GERD) |
| <input type="checkbox"/> Stroke - Year _____ | <input type="checkbox"/> Asthma – (Mild / Mod / Severe) |
| <input type="checkbox"/> Cancer – (Active or History?) Type _____ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Cancer Meds/Chemo – When? _____ | <input type="checkbox"/> Dental Anxiety (Mild / Mod / Severe) |
| <input type="checkbox"/> Radiation Therapy - Location _____ | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sensory Processing Issues |
| <input type="checkbox"/> Hepatitis - Type _____ | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Other Infectious Disease _____ | <input type="checkbox"/> Epilepsy or Convulsions |
| <input type="checkbox"/> Pregnant - Trimester _____ | <input type="checkbox"/> History of Long Term Steroid Treatments |
| <input type="checkbox"/> Trying To Get Pregnant | <input type="checkbox"/> Anaphylaxis or Severe Allergic Reaction |
| <input type="checkbox"/> Breast Feeding | <input type="checkbox"/> Autoimmune Disease _____ |
| <input type="checkbox"/> Birth Control Hormones | <input type="checkbox"/> Immune System Issues _____ |
| <input type="checkbox"/> Diabetes - Controlled Well / Fair / Poor | <input type="checkbox"/> Breathing Problems or Emphysema |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other Condition Not Listed _____ |

(YES / NO) Are you **allergic** to any medications or materials? Please check or list **ALL** allergies

- | | | |
|---|--|--|
| <input type="checkbox"/> Amoxicillin/Penicillin | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Tylenol/Acetaminophen |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Narcotics/Norco/Vicodin |
| <input type="checkbox"/> Lidocaine/Anesthetic | <input type="checkbox"/> Advil/Ibuprofen | <input type="checkbox"/> Valium/Xanax/Halcion |

Other: _____

(YES / NO) Are you taking any **medications**? – please list **ALL** meds _____

I have filled out this form accurately and to the best of my knowledge. I have had all my questions answered, and I understand that an accurate healthy history is vital to my wellbeing.

Signature: _____ Date _____

Dental History

Patient Name _____ Age _____

Please indicate if you have or have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Dental Anxiety (Mild) (Mod) (Severe) | <input type="checkbox"/> Sores or Lumps Around or in Your Mouth |
| <input type="checkbox"/> Impairment in (Speech) (Hearing) (Vision) | <input type="checkbox"/> Any Broken or Defective Teeth/Restorations |
| <input type="checkbox"/> Tooth Pain or Discomfort | <input type="checkbox"/> Periodontal Therapy |
| <input type="checkbox"/> Orthodontic Treatment (Braces/Invisalign) | <input type="checkbox"/> Bleeding Gums |

Please indicate if you have or have had any of the following Joint or facial pain symptoms:

- | | |
|---|---|
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Headaches or Facial Pain |
| <input type="checkbox"/> Jaw Joint Clicking or Popping | <input type="checkbox"/> Whiplash or Trauma to the Head |
| <input type="checkbox"/> Jaw locking or Unable to Open or Close | <input type="checkbox"/> Frequent Headaches |

Please indicate if you have or have had any of the following sleep apnea symptoms.:

- | | |
|---|---|
| <input type="checkbox"/> Daytime Tiredness or Desire to Nap | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Snoring or Other Noises During Sleep | <input type="checkbox"/> ADHD in Children |
| <input type="checkbox"/> Sleep Walking or Talking | <input type="checkbox"/> Frequent Awakening |

How Important is your dental health to you? (with 10 being the highest)

1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? (with 10 being the highest)

1 2 3 4 5 6 7 8 9 10

Please indicate if you have an immediate desire for more information on the following:

- | | |
|---|--|
| <input type="checkbox"/> Whitening of Teeth | <input type="checkbox"/> Replacing Missing Teeth |
| <input type="checkbox"/> Cosmetic Dentistry | <input type="checkbox"/> Orthodontic/Invisalign |
| <input type="checkbox"/> Replacing Metal Fillings | <input type="checkbox"/> Dental Implants |

When was your last dental cleaning?

_____month(s) ago or _____year(s) ago

When was your last dental treatment?

_____month(s) ago or _____year(s) ago

Please tell us about any other dental history that would help us get to know you:

Payment/Insurance Policy

- **Payment Policy:** Payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for all balances imposed by their insurance. You are ultimately responsible for any remaining amount unpaid by insurance. There will be a \$50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and will incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Patients are responsible for determining whether or not our providers are considered part of their insurer's network and will be responsible for all balances imposed by their insurance company. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.
- **Patient Signatures Release of Information to Insurers and Assignment of Benefits:** To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively to evaluate and administer claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.
- **Confirmation of Appointments:** Appointments will be attempted to be confirmed before your scheduled appointment. You must confirm your appointment or your appointment will be canceled.
- **Missed or Broken Appointments:** If you miss or break your appointment with less than 24 hours' notice, you will be subject to a \$50-\$100 cancellation fee.
- **Social Media/Photo Consent:** I consent to use images taken of me/my child to showcase our extraordinary care. I understand that the office may post my images on any/all social media platforms and websites.
- **Consent to Treat:** I give the dentists and dental hygienists permission to treat me in the dental office with exams, cleanings, x-rays, fillings, crowns and other dental procedures deemed advisable by our clinicians. While the vast majority of dental procedures cause little to no unwanted side effects, I understand there are risks to dental treatment, including but not limited to the following:
 - Post-anesthetic injection complications can be psychologically and physically disabling, including bruising, limited opening, pain, dysfunction, as well as nerve damage. Needles can very rarely be separated inside the tissue and require surgery to remove.
 - Aspiration of dental materials leading to emergency surgery.
 - Damage to the jaw joint can occur in susceptible individuals, leading to pain and dysfunction of the jaw joint, which can be psychologically and physically disabling.
 - Post-Surgical infections, swelling, pain, fever, and nerve damage, can occur. I understand that I must immediately notify my dentist if any of these conditions occur. I will seek emergency medical care if the infection appears to be more than minor.
 - Dental treatment is highly effective and predictable; however, in some cases, treatment fails due to various reasons including, but not limited to, pre-existing conditions such as cracks in the teeth, severe decay and bone loss, patients not following up with timely appointments to complete treatment, health issues such as diabetes and complications of smoking, complex root canal systems leading to residual infections, diets high in sugar or soda, and your general health.
 - Allergic reactions can happen in the dental office. In exceedingly rare instances, these reactions can be life-threatening.
 - Post-cleaning sensitivity can occur. This is especially true if you have periodontal disease. If this happens, please contact the office, as we have topical medications to help.
- **Communication from Bluetree Brands:** I consent to receive relevant communication from Bluetree brands and its affiliated partners.

We will do our absolute best to ensure you get the best care at our office. Please feel free to ask any questions regarding your treatment.

I have carefully read and given my consent to all the above sections on this form. I have had any questions regarding this form sufficiently answered to my satisfaction.

Patient Name: _____ Date: _____

Guardian Name if Applicable: _____

Signature of Patient/Guardian: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

Please Print Patient Name

Signature of Patient/Legal Guardian

Date

The notice contains a patient's rights section describing your rights under the law. You certify by your signature that you have reviewed our notices before signing this consent. The terms of the notices are subject to change.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement if we do. The HIPAA (Health Insurance Portability and Accountability Act of 1996 Law) allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By submitting this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as the law allows.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition treatment receipt upon this consent's execution.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You may communicate with the following individuals relating to the patient's medical or payment information:

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of our Notice of Privacy Practices was attempted, however acknowledgment could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgment
 - An emergency situation prevented us from obtaining acknowledgment
 - Other (Please Specify)
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