Welcome!

Patient Name: _____ **DOB:**_____

Address:_____ **City:** _____ **Zip Code**_____

Phone Number:_____ **Email:** _____

Emergency Contact (Name & Number): _____

Responsible Party:

Mother/ Guardian

Name:_____

DOB: _____

Phone Number: _____

Father/ Guardian

Name: _____

DOB: _____

Phone Number:_____

Insurance Information

Primary(1)

Insurance Company:_____

Client ID: _____

Employee: _____

Secondary(2)

Insurance Company: _____

Client ID: _____

Employee: _____

Medical History: Check the boxes for all that are "Yes" and Leave the boxes blank if the answers are "No"

- ☐ Tooth Pain
- ☐ Serious injury to Head/Mouth
- ☐ Dry Mouth
- ☐ Changes in Skin color
- ☐ Rashes/Hives
- ☐ Shingles
- ☐ Eye Problems
- ☐ Glaucoma
- ☐ Tooth Sensitivity to hot/cold or sweets
- ☐ Bleeding Gums
- ☐ Food/Floss catches between teeth
- ☐ Sores/Ulcers in mouth
- ☐ Orthodontic Treatment (Braces)
- ☐ Earaches/ Neck Pain
- ☐ Sinus Problems
- ☐ Pacemaker
- ☐ Psych Treatment
- ☐ ADHD
- ☐ Down Syndrome
- ☐ Spina Bifida
- ☐ Disabilities/Special Needs
- ☐ Frequent Sore Throat
- ☐ Denture/Partials
- ☐ Tire Easily
- ☐ Weight Change
- ☐ Other Gland Problems
- ☐ Hypoglycemia
- ☐ Stroke
- ☐ Emotional Problems
- ☐ Convulsions/Epilepsy
- ☐ Persistent Fever
- ☐ Take Steroids
- ☐ Bruise Easily
- ☐ Frequent Headaches
- ☐ Previous Gum Treatment
- ☐ Teeth sensitivity to chewing
- ☐ Nerve Problems
- ☐ Frequent Nosebleeds
- ☐ Heart Surgery
- ☐ Bleeding Problems
- ☐ Blood Disorder
- ☐ Sickle Cell
- ☐ Anemia
- ☐ HIV
- ☐ Clicking/Popping/ Pain in Jaw
- ☐ Grinding or clenching teeth
- ☐ Head Injury
- ☐ Rheumatic Fever
- ☐ Any Heart disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain/ Discomfort
- ☐ Loss of Hearing
- ☐ Numbness/Tingling
- ☐ Congenital Heart Disease
- ☐ Ear Infections
- ☐ Dizziness/Fainting
- ☐ Artificial Heart Valves
- ☐ Head injury
- ☐ Autism
- ☐ Heart Attack
- ☐ Down Syndrome
- ☐ Heart Murmur
- ☐ Irregular heartbeat
- ☐ High Cholesterol
- ☐ Asthma

⇨

Medical History: Check the boxes for all that are "Yes" and Leave the boxes blank if the answers are "No"

- ☐ Post Nasal Drip
- ☐ Cleft Palate
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Persistent Cough
- ☐ Broken Bones
- ☐ Changes in Appetite
- ☐ Hepatitis
- ☐ Intestinal Disease
- ☐ Venereal Disease
- ☐ Cancer
- ☐ Blood Transfusion
- ☐ Mitral Valve Problems
- ☐ Tuberculosis
- ☐ Artificial Joints
- ☐ Black/Bloody or pale stools
- ☐ Stomach Ulcers/Disease
- ☐ Renal Dialysis
- ☐ Radiation Treatment
- ☐ Emphysema/ COPD
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Kidney Transplant
- ☐ Tumors/Growths
- ☐ Autoimmune Disorders

- **List all medication you are currently taking:** _____
  _____
  _____

- **Have you ever taken Fosamax, Boniva, Actonel, or any medicine that contains bisphosphonates? (If yes, Explain)**_____

- If Yes to Diabetes Please Circle **Type 1 or Type 2** Have you checked your blood sugar today? _____
- Indicate your most recent A1 Reading? _____ Date of most recent A1C Reading? _____
- If Yes to Asthma is it controlled? _____

- **Is there anything else we should know about?** _____

Habits: Smoke_____ Alcohol_____ Drug Use_____

- **WOMEN**: Are you trying to get pregnant? _____ Nursing?_____ Taking Oral Contraceptives? _____

(Antibiotics which may be prescribed after treatments, may cause the birth control pills to be ineffective. Other methods of contraception are recommended for the duration of the affected cycle)

- **All Operations or Surgeries:**_____
  _____

I certify that I have read and fully understand this medical history form to the best of my knowledge all the preceding answers are true and correct:

Patient Signature_____ **Date:**_____

Provider Signature _____ **Date:** _____

APPOINTMENT POLICY

In effort to best provide service to our patients our Policy goes as follows: Our office must be notified 24 hours in advance to cancel/reschedule your reserved appointment, **All appointments must be confirmed** to reserve your spot on the schedule, if not they may be rescheduled or canceled. You can call, text or email to confirm said appointment. We understand that occasionally circumstances may arise that prevent patients from keeping appointments thus the first failed appointment will be excused, after the second failed appointment, you will no longer be permitted to make appointments & will be dismissed from the practice. There is a 10 minute grace period. **If you arrive 15 minutes late to your appointment with no notice it will be canceled**. After 2 canceled, missed or rescheduled appointments you will no longer be permitted to make appointments. This system is implemented to limit the amount of last minute cancellations/ no shows due to high demand for dental care. We value our Doctor/ patient relationships and will do our best to accommodate you, your communication and cooperation are very much appreciated.

By signing below i acknowledge I have read, understand and accept the Appointment Policy:

Patient Signature_____ **Date:** _____

FINANCIAL POLICY

Full payment is due at the time of service, we accept cash (EXACT cash), most major credit cards and Alphaeon Credit. Your insurance policy is a contract between you and your insurance company. **We have no control over their decisions and the amount they decide to pay.** Before treatment we will verify your coverage and calculate your deductible and co payments as accurately as possible. Please understand that all treatment plans given are only an ESTIMATE based on the information your insurance company provides. All deductibles and copays are due the day treatments is rendered. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** At your discretion, any unpaid balance after 90 days will be sent to collections at which time the patient is responsible for any fees associated with the collection of the balance.

By signing below i acknowledge I have read, understand and accept the Financial Policy:

Patient Signature_____ **Date:**_____

I hereby give permission to discuss all aspects of my dental treatment to the individuals listed below:

Mother Father Son Partner

Husband Wife Daughter Other: (Specify)_____

Informed Consent Form for General Dental Procedures

Our patients have the right to refuse the recommended dental treatment proposed by their dentist. Your dentist and dental team will thoroughly communicate with you the ideal and alternative treatment options, the risk associated with both, and the ridl of no treatment, before you are asked to give consent. Do not give consent to treatment unless you are satisfied with the answers conveyed to you by your dental team and all of your questions have been answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during and after treatment. It is also important that you follow your dentist's advice and recommendations regarding medications, pre and post treatment instructions, referrals to specialists, and the necessity to return for scheduled appointments. Failure to follow the advice and recommendations of your dentist may result in a poor outcome. Certain heart conditions may create a risk of serious or fatal complications. If you have a serious heart condition, or are taking blood thinners or anticoagulants, advise your dentist immediately so he/she can consult with your physician. In dentistry, there are commonly known risks and potential complications associated with dental treatment. No provider can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Although these complications are are rare, they can and do occur occasionally.

MEDICATIONS & SEDATION: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and or anaphylactic shock. They may cause drowsiness and a lack of awareness and coordination, which may be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for ym treatment. I understand that failure to take medications in the manner prescribed may increase the likelihood of continued or aggravated infection or pain, as well as the potential resistance towards future treatment of my condition. WOMEN: I understand that antibiotics can decrease the the effectiveness of birth control.

CHANGES IN TREATMENT: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during the initial exam (ie. root canal therapy following routine restorative procedures). My dentist will discuss any modifications to the original treatment plan with me prior to completing treatment.

TMJ DYSFUNCTION: I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw following following the routine dental treatment caused by the mouth being opened for a prolonged period of time. However the symptoms of TMJ dysfunction associated with dental treatment there are usually transitory in nature and well tolerated by most patients. I understand that should the need for the treatment arise, then i will be referred to a specialist for treatment, and the cost of which is my responsibility. **FILLINGS**: I understand that care must be exercised in chewing on recently restored teeth during the first 24 hours to prevent breakage of the filling and sensitivity is a common after effect of a newly placed filling.

By signing I understand that dentistry is not an exact science therefore comprehend that results cannot be guaranteed. I acknowledge that no guarantee or assurance had been made by anyone regarding the dental treatment which i have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than my treating dentist is responsible for my dental treatment, however I understand that the providers of this office can refuse treatment of previous restorative treatment done by other dental providers depending on the severity of the case. This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood and accepted each paragraph stated above. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment. This form will remain in effect until terminated by this dental office or you.

Patient Signature_____ **Date:**_____

Witness Signature (Office Staff) _____ **Date:** _____

Acknowledgment of Receipt of Notice of Privacy Practices

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy practices, which states how we may use and or disclose your health information. Please sign this form to acknowledge receipt of this notice. **You may refuse to sign this acknowledgment is you wish or if you prefer not to get the Notice of privacy practices packet.**

I acknowledge that I have received a copy of this offices Notice of Privacy Practices.

Patient/ Responsible Party Signature: _____

Date:_____

*** If the patient refuses to sign any of the offices policies,we will not proceed with the appointment, full understanding and compliance is needed to move forward with treatment for the safety of the patient and our staff ***

If you have any further questions please feel free to ask your providers.

OFFICE USE ONLY

Notice of Privacy Practices was not obtained because of the following:

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