DERBY DENTAL

Patient Information

Date _____

☐Mr. ☐Mrs. ☐Ms. ☐Dr. Name _____
First MI Last Nickname

Marital Status: ☐Married ☐Single ☐Minor Sex: ☐ Male ☐ Female

Birth Date _____/_____/_____ SS# _____-_____-_____ Drivers License # _____

Phone (Home) _____ (Cell) _____ (Work) _____ ext: _____

E-Mail Address _____

Address _____
Street or P.O. Box Apt# City State Zip

Place of Employment _____ Occupation/Position _____

In case of emergency, please contact _____ Tel: _____

Who were you referred by? _____

Pharmacy _____ Pharmacy Phone # _____

Who will be responsible for your account?

☐Self ☐Spouse ☐Father ☐Mother ☐ Other _____ (***if self, skip to next section***)

Name _____ Birth Date _____/_____/_____ SSN_____-_____-_____

Address _____
Street or P.O. Box Apt# City State Zip

Primary Dental Insurance Company

Employee/Subscriber Name_____ Employer _____

Birth Date ____/____/____ SSN _____-_____-_____

If you have your insurance card, we can make a copy and you may skip this portion.

Insurance Company Name_____

Group/Employer# _____ ID# _____

Dental History

Previous Dentist_____ How long had you been a patient? _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) _____	❑	❑
Have you ever had complications from past dental treatment?	❑	❑
Have you ever had an unfavorable dental experience?	❑	❑
Have you ever had trouble getting numb or had any reactions to local anesthetic?	❑	❑
Did you ever have braces, orthodontic treatment, or had your bite adjusted?	❑	❑
Have you ever had any teeth removed or missing teeth that never developed?	❑	❑
GUM AND BONE		
Do your gums bleed or are they painful when brushing or flossing?	❑	❑
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	❑	❑
Have you ever experienced gum recession?	❑	❑
Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
Have you ever experienced a burning sensation in your mouth?	❑	❑
Have your teeth ever become loose on their own? (without injury)	❑	❑
Is there anyone in your family with a history of periodontal disease?	❑	❑
Have you experienced a burning or painful sensation in your mouth not related to your teeth?	❑	❑
TOOTH STRUCTURE		
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	❑	❑
Do you frequently get food caught between any teeth?	❑	❑
Have you had any cavities within the past three years?	❑	❑
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	❑	❑
Do you feel or notice any holes on the biting surface of your teeth?	❑	❑
BITE AND JAW JOINT		
Do you have problems with your jaw joint?	❑	❑
Do you feel like your lower jaw is being pushed back when you bit your teeth together?	❑	❑
Do you avoid or have trouble chewing gum, carrots, nuts, bagels, or other hard, dry food?	❑	❑
Are your teeth becoming more crooked, crowded, or overlapped?	❑	❑
Are your teeth developing spaces or becoming more loose?	❑	❑
Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	❑	❑
Do you clench your teeth in the daytime or make them sore?	❑	❑
Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
--If yes, have you had a sleep study performed?	❑	❑
Do you wear or have you ever worn a bite appliance?	❑	❑
SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change?	❑	❑
Have you ever whitened (bleached) your teeth?	❑	❑
Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?	❑	❑
Have you ever been disappointed with the appearance of previous dental work?	❑	❑

Medical History

Patient Name: _____

Date of most recent exam: _____

Name of Physician/specialty:

_____

What is your estimate of your general health?
☐Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

An allergic reaction to:

- ☐aspirin, ibuprofen, acetaminophen, codeine
- ☐penicillin
- ☐erythromycin
- ☐tetracycline
- ☐sulfa
- ☐local anesthetic
- ☐fluoride
- ☐metals (nickel, gold, silver, _____)
- ☐latex
- ☐other _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
Heart problems, or cardiac stent (last 6 months)	❑	❑
Artificial heart valve, repaired heart defect (PFO)	❑	❑
Pacemaker or implantable defibrillator	❑	❑
History of infective endocarditis	❑	❑
Artificial prosthesis (heart valve or joints)	❑	❑
Rheumatic or Scarlet fever	❑	❑

	YES	NO
High or low blood pressure	❑	❑
A stroke (taking blood thinner)	❑	❑
Anemia or other blood disorder	❑	❑
Emphysema, sarcoidosis	❑	❑
Tuberculosis	❑	❑
Asthma	❑	❑
Thyroid, parathyroid disease, or calcium deficiency	❑	❑
High cholesterol or taking statin drugs	❑	❑
Diabetes (HbA1c=_____)	❑	❑
Digestive disorders (i.e. gastric reflux)	❑	❑
Osteoporosis/osteopenia (i.e. taking bisphosponates)	❑	❑
Arthritis	❑	❑
Glaucoma	❑	❑
Head/neck injuries	❑	❑
Epilepsy, convulsions (seizures)	❑	❑
Neurological problems (ADD/ADHD)	❑	❑
Viral infections and cold sores	❑	❑
Any lumps/swelling in the mouth	❑	❑
Hives, skin rash, hay fever	❑	❑
Hepatitis (Type _____)	❑	❑
HIV/AIDS	❑	❑
Tumor/Abnormal growth	❑	❑
Radiation therapy	❑	❑
Chemotherapy	❑	❑
Antidepressant medication	❑	❑

ARE YOU:		
Presently being treated for any other illness	❑	❑
Aware of a change in your health (i.e. fever, new cough)	❑	❑
Taking medication for weight management	❑	❑
Taking dietary supplements	❑	❑
Experiencing frequent headaches	❑	❑
A smoker, smoked previously, or used smokeless tobacco	❑	❑
FEMALE-taking birth control pills	❑	❑
FEMALE-pregnant	❑	❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, collagen injections)

_____

List all medications, supplements, and/or vitamins taken within the last two years:

DRUG	PURPOSE

Patient's Signature **Date**

Doctor's Signature **Date**

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Financial Policy

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the care you need. We accept cash, checks, VISA, MasterCard, Discover, and American Express. We have also partnered with a third-party company, Care Credit, to offer flexibility of deferred interest and extended payment options.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered.
Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company within 90 days of date of service.** In the event that your account is turned over to the collection agency, you are responsible for the balance, as well as all collections and/or attorney's fees.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment.

Minor Patients

Please be advised that we do not split billing for children whose parents are divorced. **The parent or guardian who brings the child to their appointment is responsible for payment.**

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at the time of services has been verified.

Broken Appointment Policy

We kindly request at least 48 hours advance notice if you are unable to keep your appointment. The office fee for a broken appointment is **$50 per hour of reserved time** and is to be paid *prior* to the scheduling of any new appointment.

I have read the above policy. I understand and agree to abide by the terms outlined.

Signature of Patient *(Parent or Guardian if minor)* X_____ **Date X**_____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.
I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient *(Parent or Guardian if minor)* X_____ **Date X**_____

Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Name:	Date of Birth:

This consent form allows Derby Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Derby Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Derby Dental.

____ I hereby authorize Derby Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and 2) Information related to billing and payment.

____ I hereby authorize that Derby Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

____ I hereby authorize that Derby Dental may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

____ I hereby authorize that Derby Dental may disclose my personal health information to the person who I have listed as my emergency contact.

I hereby authorize that Derby Dental may disclose my personal health information to the following persons:

Name	Tel. No.	Relationship to Patient

Furthermore, my (or my child's) personal health information may not be disclosed to the following person(s):

Name	Tel. No.	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Derby Dental services may still use information to complete and actions that it began prior to my revoking consent and which may rely on my protected health information. I understand that Derby Dental may refuse service if I revoke this consent.

I understand that I have the right to request—now and in the future—how protected health information is used or disclosed to carry out treatment, payment, and health care operations, and must be provided by me in writing. I understand that while Derby Dental is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient *(Parent or Guardian if minor)* X_____ **Date X**_____