**Team Family Dental**

Date:

**Patient Name:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Date of Birth:** _____

**Email Address:** _____

**Address:** _____

Parent/Guardian/Responsible Party **Name:** _____

_____

Parent/Guardian/Responsible Party **Soc. Sec #:** _____

**Insurance Company :** _____

Parent/Guardian/Responsible Party **Date of Birth:** _____

## Are you happy with your smile? ☐ YES ☐ NO

**Medical Information**

Please mark (X) your responses to indicate if you have or have not had any of the following.

| | YES | NO |
|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medication? | ☐ | ☐ |
| **If yes, please list all**, including vitamins, natural or herbal preparations and/or diet supplements: _____ | | |
| **Pharmacy:** _____ **Phone:** _____ | | |
| Do you use tobacco? | ☐ | ☐ |
| Do you drink alcoholic beverages? | ☐ | ☐ |
| Do you use controlled substances (Drugs)? | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Are you under the care of a physician? | ☐ | ☐ |
| **Physician Name:** _____ **Phone:** _____ | | |
| **Date of last physical exam:** _____ | | |
| Has there been any changes in your general health within the past year? | ☐ | ☐ |
| If YES, what condition is being treated? _____ | | |
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ |
| If YES, what was the illness or problem? _____ | | |

**JOINT REPLACEMENT:**

| | YES | NO |
|---|---|---|
| Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ |

If yes, Date: _____ Any complications? _____

**PREMEDICATION:**

| | YES | NO |
|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment. Name and phone number of physician or dentist and making recommendation: _____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ |

Date Treatment began: _____

**Please See Next Page**

**Please mark (X) your response to indicate if you have or have not had any of the follo**

**ALLERGIES -**Are you allergic to or ever had a reaction to any of the following. **Any yes responses, specify type of reaction.**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Local anesthetics | ☐ | ☐ | Metals | ☐ | ☐ |
| Aspirin | ☐ | ☐ | Latex (rubber) | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ | Iodine | ☐ | ☐ |
| Barbiturates, sedatives, sleeping pills | ☐ | ☐ | Hay fever/seasonal | ☐ | ☐ |
| Sulfa drugs | ☐ | ☐ | Food | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | Other | ☐ | ☐ |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Artificial (prosthetic) Heart Valve | ☐ | ☐ | Congenital heart disease (CHD) | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | Unrepaired, cyanotic CHD | ☐ | ☐ |
| Previous Infections Endocarditis | ☐ | ☐ | Repaired (completely) in last 6 months | ☐ | ☐ |
| | | | Repaired CHD with residual defects | ☐ | ☐ |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | Sinus Trouble | ☐ | ☐ |
| Angina | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | Cancer/Chemotherapy/Radiation Treatment | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | Chronic Pain | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | Diabetes Type I or Type II | ☐ | ☐ |
| Heart attack | ☐ | ☐ | Malnutrition | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | Gastrointestinal disease | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | G.E. Reflux/persistent heartburn | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Other Congenital heart defects | ☐ | ☐ | Thyroid problems | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | Stroke | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | Hepatitis, jaundice, or liver disease | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | Fainting spells or seizures | ☐ | ☐ |
| Anemia | ☐ | ☐ | Neurological disorders, If yes, specify: _____ | ☐ | ☐ |
| Blood transfusion, If yes, date: _____ | ☐ | ☐ | Recurrent infections, Type of infection: _____ | ☐ | ☐ |
| Hemophilia | ☐ | ☐ | _____ | | |
| Arthritis | ☐ | ☐ | AIDS or HIV infection | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | Kidney problems | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Systemic lupus erythematous | ☐ | ☐ | Persistent swollen glands in neck | ☐ | ☐ |
| Asthma | ☐ | ☐ | Severe headaches/migraines | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | Severe or rapid weight loss | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Sexually transmitted disease | ☐ | ☐ |
| Do you have any disease, condition, or problem not listed above that you think I should know about? Please Explain _____ | | | | ☐ | ☐ |

| **THIS BOX: WOMEN ONLY:** Are you: | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Pregnant? | ☐ | ☐ | Nursing? | ☐ | ☐ |
| Number of weeks: _____ | | | Taking birth control/hormonal replacement | ☐ | ☐ |

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Signature of Patient/Legal Guardian:** _____ **Date:** _____

# Authorization and Release

## Financial Agreement:

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

## Insurance Filing:

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and your insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

## Assignment of Benefits:

I, the undersigned, assign directly to Team Family Dental all benefits, otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I accept full financial responsibility for all charges not covered by insurance.

## Delinquent Accounts:

All delinquent accounts (90 days or older) are subject to reasonable service charges and/or legal interest rates.

## Collection Proceedings:

In the event that your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service.

## Appointments:

I understand to be here, on time, for my scheduled appointment. If I am unable to keep my appointment, I need to give at least 24 hours notice. If I fail to show for my appointment, without notice, I understand I will be charged. Habitual no shows or late cancellations of appointments may be grounds for dismissal from the practice.

_____ _____

**Responsible Party's Signature** **Date**

**PLEASE SEE NEXT PAGE**

# Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received Team Family Dental's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information, individual rights, and Team Family Dental's legal duties with respect to my protected health information. The notice includes:

- A statement that Team Family Dental is required by law to maintain the privacy of protected health information.
- A statement that Team Family Dental is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that Team Family Dental is permitted to make for each of the following purposes: Treatment, Payment, and Healthcare Operations
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:
  - The rights to complain to Team Family Dental and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that Team Family Dental is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from Team Family Dental upon request.

Team Family Dental reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Team Family Dental's current Notice of Privacy Practices upon request.

Signature: _____ Date: _____